APPENDICES

This guide was developed to assist you in organizing your loved one's care. The following appendices can be used to help you organize yourself. Pick the ones that fit your needs, and adapt them as you see fit.

In the following pages you will find:

MEDICAL HISTORY TEMPLATE

Name: _____ Blood Type: _____ Positive Negative

Date	Medical Condition/Surgery/Injury	Comments

MEDICAL POWER OF ATTORNEY FORM*

DESIGNATION OF HEALTHCARE AGENT

I, (insert your name) _____

Appoint: (name) _____

Address: _____

_____

Phone: _____

as my agent to make any and all healthcare decisions for me, except to the extent I state otherwise in this document. This Medical Power of Attorney takes effect if I become unable to make my own healthcare decisions and my physician certifies this fact in writing.

LIMITATIONS ON THE DECISION-MAKING AUTHORITY OF MY AGENT ARE AS FOLLOWS:

_____

_____

_____

Designation of Alternate Agent

(You are not required to designate an alternate agent but you may do so. An alternate agent may make the same healthcare decisions as the designated agent if the designated agent is unable or unwilling to act as your agent. If the agent designated is your spouse, the designation is automatically revoked by law if your marriage is dissolved.)

If the person designated as my agent is unable or unwilling to make healthcare decisions for me, I designate the following persons to serve as my agent to make healthcare decisions for me as authorized by this document, who serve in the following order:

**This guide does not replace legal council. Consult with a lawyer for all questions and/or concerns.*

First Alternate Agent

Name: _____

Address: _____

_____

Phone: _____

Second Alternate Agent

Name: _____

Address: _____

_____

Phone: _____

The original of this document is kept at _____

_____

_____

The following individuals or institutions have signed copies:

Name: _____

Address: _____

_____

Phone: _____

Name: _____

Address: _____

_____

Phone: _____

**This guide does not replace legal council. Consult with a lawyer for all questions and/or concerns.*

Duration
I understand that this medical power of attorney exists indefinitely from the date I execute this document unless I establish a shorter time or revoke the medical power of attorney. If I am unable to make healthcare decisions for myself when this medical power of attorney expires, the authority I have granted my agent continues to exist until the time I become able to make healthcare decisions for myself.

(IF APPLICABLE) This medical power of attorney ends on the following date: _____

Prior Designations Revoked
I revoke any prior Medical Power of Attorney.

Acknowledgment of Disclosure Statement
I have been provided with a disclosure statement explaining the effect of this document. I have read and understand that information contained in the disclosure statement.

(YOU MUST DATE AND SIGN THIS POWER OF ATTORNEY.)

I sign my name to this Medical Power of Attorney on
_____ day of _____ month _____ year

at_____.
(City and State)

_____
(Signature)

_____
(Print Name)

Statement of Witness
I am not the person appointed an agent by this document. I am not related to the principal by blood or marriage. I would not be entitled to any portion of the principal's estate on the principal's death. I am not the attending physician of the principal or an employee of the attending physician. I have no claim against any portion of the principal's estate on the principal's death. Furthermore, if I am an employee of a healthcare facility in which the principal is a patient, I am not

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involved in providing direct patient care to the principal and am not an officer, director, partner or business office employee of the healthcare facility or of any parent organization of the healthcare facility.

Signature: _____

Print Name:_____

Address: _____

_____

Date: _____

Signature: _____

Print Name:_____

Address: _____

_____

Date: _____

Source: Texas Medical Association. (1999). Medical power of attorney. www.texmed.org.

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QUESTIONS TO ASK HEALTHCARE PROFESSIONALS

- What caused the stroke?

- What type of stroke was it?

- Where in the brain did it occur?

- What kinds of tests have already been done?

- What types of physical problems may arise post-stroke and how do we treat them?

- What types of emotional problems may arise post-stroke and how do we treat them?

- Is rehabilitation necessary? If yes, ask about specific prescriptions/referrals.

Add your questions here:

FINDING A REHABILITATION (REHAB) PROGRAM CHECKLIST

Name of Program: _____

About The Program	Yes	No	Notes
Does the program have a full-time physiatrist or other healthcare professional who is experienced in stroke and rehab medicine on staff?	☐	☐	
Does the program provide a wide range of therapy services? (Physical therapy, occupational therapy or speech therapy)	☐	☐	
Does the program provide the specific services the stroke survivor needs?	☐	☐	
Does the program have a formal system for evaluating the progress made by its patients and the overall outcomes of the stroke rehab program?	☐	☐	
Does the program have any partners that offer rehab services at other levels of care that the stroke survivor may eventually need? (Day treatment, outpatient treatment or home care)	☐	☐	
Are staff members required to keep up with new information about stroke and rehab? How do they do so?	☐	☐	
Does the program match the stroke survivor's abilities, or is it too demanding or not demanding enough?	☐	☐	
Is medical care available at the rehab center if needed?	☐	☐	

Can the stroke survivor's healthcare professional visit him/her at the rehab center?	☐	☐	
Does the program have a stroke support group for survivors and their families? If not, can they make a referral to a local group?	☐	☐	
Does the program use outside groups (such as consumer advocacy groups) to get ideas for serving people with disabilities?	☐	☐	
Does the program conduct home visits before checking people out of the center and releasing them to their homes?	☐	☐	
Has the program been in operation at least one year?	☐	☐	
TREATMENTS & SERVICES	Yes	No	Notes
Does the program provide the specific services the stroke survivor needs?	☐	☐	
Is the stroke survivor eligible for those treatments?	☐	☐	
Will there be bilingual staff members?	☐	☐	
Will there be sign language interpreters?	☐	☐	
Will medical information be explained in simple terms?	☐	☐	
Is help available with discharge? How does it work?	☐	☐	
What percentage of people will return home after discharge?	N/A	N/A	
What percentage of people will be placed in nursing homes?	N/A	N/A	

LOCATION	Yes	No	Notes
If it is an outpatient program, is transportation available?	☐	☐	
Is the location convenient?	☐	☐	
Is the location close to public transportation?	☐	☐	
HOURS	**Yes**	**No**	**Notes**
Are the days and times convenient for the stroke survivor?	☐	☐	
What are the visiting hours?	☐	☐	
Are the visiting hours convenient for family and friends?	☐	☐	
Are the visiting hours long enough for a good quality visit?	☐	☐	
COST & INSURANCE	**Yes**	**No**	**Notes**
What is the estimated cost of treatment?	N/A	N/A	
Will the stroke survivor's insurance plan or government funding (Medicare, Medicaid, state health plans) cover all or part of the cost?	☐	☐	
Will the staff help with health insurance claims or appeals, if needed?	☐	☐	
What is the average total cost for the complete stroke program? (Acute rehabilitation, home care and outpatient)	N/A	N/A	

APPENDIX D

CUSTOMER SERVICE & SATISFACTION	Yes	No	Notes
Does the program collect information from patients and their families about satisfaction with the care received?	☐	☐	
If so, is the feedback generally positive?	☐	☐	
Can I talk to other people who have used the services?	☐	☐	
How long do most stroke survivors stay in the program?	N/A	N/A	

Notes:

MEDICATION TRACKER TEMPLATE

Mark the top of a medication bottle with the corresponding number to help manage and identify each medication.

Medications	Dosage	Morning	Noon	Afternoon	Night	How Does the Med Make You Feel?	Date of Last Med/Dose Change	Comments	Date of Next Refill
SAMPLE									
#1= Baclofen	10mg	X	X		X		12-2011	For spasticity	2-2012
1=									
2=									
3=									
4=									
5=									
6=									
7=									
8=									
9=									
10=									
11=									
12=									
As Needed=									

Patient Name: _____

Primary Care Provider: _____ Phone: _____

Pharmacy: _____ Phone: _____

Medication Allergies: _____

Food Allergies: _____

APPENDIX F

EMERGENCY CONTACT INFORMATION TEMPLATE

Patient Name: _____

Home Phone: _____

Address: _____

_____

Who to Call

First Contact: NAME: _____

Number: _____Home/Cell/Work

Number: _____Home/Cell/Work

Second Contact: NAME: _____

Number: _____Home/Cell/Work

Number: _____Home/Cell/Work

Third Contact: NAME: _____

Number: _____Home/Cell/Work

Number: _____Home/Cell/Work

PHYSICIAN INFORMATION TEMPLATE

Patient Name: _____

Primary Care Provider:

Name: _____

Physician Assistant or Nurse Practitioner: _____

Phone Number: _____

Neurologist:

Name: _____

Phone Number: _____

Cardiologist:

Name: _____

Phone Number: _____

Nephrologist:

Name: _____

Phone Number: _____

Other (Type): _____

Name: _____

Phone Number: _____

Other (Type): _____

Name: _____

Phone Number: _____

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National Stroke Association's mission is to reduce the incidence and impact of stroke by developing compelling education and programs focused on the prevention, treatment, rehabilitation and support for all impacted by stroke.

A stroke is a brain attack that occurs when a blood clot blocks an artery or a blood vessel breaks, interrupting blood flow to an area of the brain. Brain cells begin to die.

CALL 9-1-1 IMMEDIATELY IF YOU SEE ONE OR MORE SIGNS OF A STROKE.

National STROKE Association™

1-800-STROKES
(787-6537)

www.stroke.org

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