HarborQuay
HELPING FAMILIES NAVIGATE CARE TOGETHER

HARBORQUAY FAMILY CARE BINDER

Emergency Contact & Information Sheet

IN AN EMERGENCY: Bring this sheet and the current medication list.

LOVED ONE INFORMATION

Full Name: _____
Preferred Name: _____
Date of Birth: _____
Address: _____
_____
Blood Type (if known): _____
Allergies: _____
_____

MEDICAL TEAM

Primary Physician
Name: _____
Phone: _____

Specialist
Name: _____
Specialty: _____
Phone: _____

Pharmacy
Name: _____
Phone: _____
Address: _____
_____

IMPORTANT MEDICAL INFORMATION

Check any that apply:

- ☐ Diabetes
- ☐ Heart Condition
- ☐ High Blood Pressure
- ☐ Stroke History
- ☐ Dementia / Memory Loss
- ☐ Fall Risk
- ☐ Oxygen Use
- ☐ Mobility Limitations
- ☐ Hearing Impairment
- ☐ Vision Impairment
- ☐ COPD / Lung Disease
- ☐ Kidney Disease
- ☐ Cancer
- ☐ Seizure Disorder
- ☐ Other: _____

Other important notes:
_____
_____
_____

HOSPITAL PREFERENCE

Preferred Hospital / ER: _____
Address / Phone: _____
_____

If no preference, go to the nearest appropriate facility.

PRIMARY EMERGENCY CONTACTS

CONTACT 1
Name: _____
Relationship: _____
Phone: _____
Alternate Phone: _____

CONTACT 2
Name: _____
Relationship: _____
Phone: _____
Alternate Phone: _____

CONTACT 3
Name: _____
Relationship: _____
Phone: _____
Alternate Phone: _____

INSURANCE INFORMATION

Insurance Provider: _____
Policy Number: _____
Medicare / Medicaid ID: _____
Supplemental Plan: _____
Group Number (if applicable): _____

LEGAL DOCUMENTS

Check what is available and where it is stored.

- ☐ Advance Directive — Location: _____
- ☐ Living Will — Location: _____
- ☐ DNR — Location: _____
- ☐ Medical Power of Attorney — Location: _____
- ☐ Financial Power of Attorney — Location: _____
- ☐ Other Important Documents — Location: _____

IMPORTANT NOTES FOR EMERGENCY RESPONDERS

_____
_____
_____
_____

Prepared today. Peace of mind tomorrow.
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Medication Tracker

Keep track of medications, dosages, and schedules to ensure safe and consistent care.

Loved One's Name: _____ Allergies: _____

Date of Birth: _____ _____

Primary Physician: _____ Emergency Contact: _____

Pharmacy: _____ Phone: _____

CURRENT MEDICATIONS

Medication Name *(Generic/Brand)*	Purpose / Condition *Treated*	Dosage *(mg, etc.)*	Time / Frequency *(ex: 1 tab, 2x daily)*	Prescribing Doctor	Notes / Side Effects

DAILY MEDICATION LOG

Date	Morning	Noon	Evening	Bedtime	Notes
	☐	☐	☐	☐	
	☐	☐	☐	☐	
	☐	☐	☐	☐	
	☐	☐	☐	☐	
	☐	☐	☐	☐	
	☐	☐	☐	☐	
	☐	☐	☐	☐	

MEDICATION CHANGES / REACTIONS

Date	Change Made *(New / Stopped / Dosage Change)*	Reason	Side Effects / Notes

QUESTIONS FOR DOCTOR / PHARMACY

_____

_____

_____

_____

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Doctor Appointment

INFORMATION SHEET • PAGE 1 OF 2

A little preparation can help you get the most out of your appointment.
Complete the form prior to your visit then bring it with you.

1 APPOINTMENT DETAILS

Loved One: _____ Date: _____

Doctor / Specialist: _____ Time: _____

Clinic / Hospital: _____ Phone: _____

Reason for Visit: _____

_____

2 SYMPTOMS / CONCERNS SINCE LAST VISIT

What changes have you noticed?

- ☐ Increased fatigue
- ☐ Appetite changes
- ☐ Weight changes
- ☐ Pain / discomfort
- ☐ Mood changes
- ☐ Sleep changes
- ☐ Memory changes
- ☐ Balance / falls
- ☐ Medication concerns
- ☐ Bowel / bladder concerns
- ☐ Shortness of breath
- ☐ Other: _____

Please describe: _____

_____

_____

3 QUESTIONS TO ASK THE DOCTOR

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Tip: Write your questions down so nothing gets forgotten.

4 MEDICATION QUESTIONS

- ☐ Is each medication still necessary?
- ☐ Are there side effects to watch for?
- ☐ Any dosage changes needed?
- ☐ Drug interactions to consider?
- ☐ Can anything be simplified?

Other medication questions or notes:

_____

_____

_____

_____

You do not have to do this alone. We're in this together.

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Doctor Appointment

INFORMATION SHEET • PAGE 2 OF 2

Take notes during the appointment and use this page to capture everything so you can focus on what matters most — their care.

NOTES FROM TODAY'S VISIT

What did the doctor say?

Important information, explanations, or recommendations:

INSTRUCTIONS / NEXT STEPS

- [ ] New medication prescribed
- [ ] Medication changed
- [ ] Lab work ordered
- [ ] Imaging / test ordered
- [ ] Specialist referral
- [ ] Therapy recommended
- [ ] Follow-up appointment needed
- [ ] Other: _____

Details / Notes:

FOLLOW-UP APPOINTMENT

Recommended follow-up date: _____

Doctor / Specialist: _____

Reason: _____

Location: _____

Phone: _____

FOLLOW-UP TASKS

TASK	WHO HANDLES IT?	COMPLETE
Schedule follow-up appointment		☐
Pick up prescription		☐
Complete lab work / tests		☐
Call specialist		☐
Insurance / paperwork		☐
Other:		☐

WHAT MATTERS MOST TO OUR FAMILY RIGHT NOW

What are we hoping to improve?

- [ ] Comfort
- [ ] Mobility
- [ ] Caregiver support
- [ ] Independence
- [ ] Safety
- [ ] Other: _____
- [ ] Pain management
- [ ] Quality of life

Notes:

You're showing up for their care in a big way. You're not alone.

Prepared today. Peace of mind tomorrow. *HarborQuay is here for you.*