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This Healthcare Management Binder is sponsored by



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Our Three-Fold Mission of Support, Education, and Research

- **Support:** To help patients and their families cope with scleroderma through mutual support programs, peer counseling, physician referrals, and educational information.
- **Education:** To promote public awareness and education through patient and health professional seminars, literature, and publicity campaigns.
- **Research:** To stimulate and support research to improve treatment and ultimately find the cause of and cure for scleroderma and related diseases.

While the Foundation allocates an average of \$1 million in funds per year for research into the cause and cure of scleroderma, we also consider the other two parts of our mission very important.



Contact Us -

Scleroderma Foundation

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Scleroderma Foundation: 800-722-4673 (HOPE)

Fax 978-463-5809

www.scleroderma.org

Disclaimer

Because the manifestations and severity of scleroderma vary among individuals, personalized medical management is essential. The Scleroderma Foundation has created the medical management binder as a tool and strongly recommends all treatments be discussed with the patients' physician(s) for proper evaluation and treatment recommendations.







Personal Information

Name:	Gender: M F					
	SS#:					
Address:	DOB:					
	Place of Birth:					
Country:	Religion:					
Home Phone:	Organ Donor: Y N					
Work Phone:	Blood Type:					
Cell Phone:	Accept Blood Transfusions: Y N					
Primary Care Physician:	Phone #:					
Emergency Contact Name:	Phone #:					
Emergency Contact Address:	Phone 2 #:					
	Relationship:					
Emergency Contact Name:	Phone #:					
Emergency Contact Address:	Phone 2 #:					
	Relationship:					
Medical Conditions:						
Allerwice to Medications.						
Allergies to Medications:						
Food or Environmental Allergies:						

Employment Information

Employer:		Student: Y N					
Address:	Employer Phone) 9:					
	Job Description	:					
Insurance Information							
Primary Insurance Company:							
Address:	Phone #:						
	Policy #:						
	Group #:						
Name of Policy Holder:	Relationship:						
Secondary Insurance Company:							
Address:	Phone #:						
	Policy #:						
	Group #:						
Name of Policy Holder:	Relationship:						
Medicaid #:							
Medicare #:							
Comments							

Current Medications

Pharmacy:	Pharmacy #2:
Phone #:	Phone #:

Medication Record

Medication Name & Strength	Dose	Time(s)	# Times/Day	Date Started	Reason for Taking

Comments		

Current Medications - Cont.

Medication Name & Strength	Dose	Time(s)	# Times/Day	Date Started	Reason for Taking

	<u> </u>	<u> </u>	 <u> </u>
Comments			
Comments			

Pulmonary Records

Echocardiogram (Annual Screenings Recommended)

Date	Location	Result	Record Obtained

Pulmonary Function Tests (PFTs)

Date	Location	Result

Pulmonary Records - Cont.

Blood Pressure Record

Date	Time	Position (e.g. sitting)	Arm R or L	Location	Reading	Pulse

GI Symptom Tracker

Symptom	Date	Time	Treatment	Comments

Comments			

Weight Record

Date	Weight	Time of Day	Special Diet / Comments

Comments		

Dental Information

Name of Dentist:	Phone #:
Address:	Comments:
Primary Dental Insurance:	
Address:	Phone #:
	Policy #:
	Group #:
Name of Policy Holder:	Relationship:

Xerostomia (Dry Mouth) Record

Date	Name of Dentist	Xerostomia Testing	Results	Complications / Comments / Treatment
1				

Dental Exam Record

Date	Name of Dentist	Cleaning	Exam	Fluoride	X-ray	Follow Up	Comments

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Comments						
Comments						

Diagnostic Tests / Blood Work

Date	Location	Type of Test	Reason	Records Received
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
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				☐ Yes ☐ No
Comments				

Diagnostic Tests / Blood Work - Cont.

Date	Location	Type of Test	Reason	Records Received
				☐ Yes ☐ No
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				☐ Yes ☐ No
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				☐ Yes ☐ No
Comments				

History of Hospitalizations and Surgeries

Hospital:		Date Admitted	Date of Surgery	Date Discharged
Phone: Address:	☐ Inpatient ☐ Outpatient	Reason for Hospit	alization / Type of S	Surgery:
Name of Doctor / Surgeon:		Complications:		
Hospital:		Date Admitted	Date of Surgery	Date Discharged
Phone:	☐ Inpatient	Reason for Hospit	alization / Type of S	Gurgery:
Address:				
Name of Doctor / Surgeon:		Complications:		
Hospital:		Date Admitted	Date of Surgery	Date Discharged
Phone:	☐ Inpatient ☐ Outpatient	Reason for Hospit	alization / Type of S	Surgery:
Address:				
		Complications:		
Name of Doctor / Surgeon:				
Comments				

History of Hospitalizations and Surgeries - Cont.

Hospital:		Date Admitted	Date of Surgery	Date Discharged
Phone:	☐ Inpatient ☐ Outpatient	Reason for Hospitalization / Type of Surgery:		
Address:				
		Complications:		
Name of Doctor / Surgeon:				
Hospital:		Date Admitted	Date of Surgery	Date Discharged
Phone:	☐ Inpatient ☐ Outpatient	Reason for Hospit	alization / Type of S	urgery:
Address:				
		Complications:		
Name of Doctor / Surgeon:				
Hospital:		Date Admitted	Date of Surgery	Date Discharged
Phone:	☐ Inpatient☐ Outpatient	Reason for Hospit	alization / Type of S	urgery:
Address:				
		Complications:		
Name of Doctor / Surgeon:				
Comments				

Optometry/Opthamology Treatment Record

Date	Name of Doctor / Reason for Visit	Comments

Optometry/Opthamology Treatment Record - Cont.

Date	Name of Doctor / Reason for Visit	Comments

Specialist Visits

Scleroderma patients experience a broad spectrum of symptom manifestations. These medical issues cause there to be a need to visit a number of healthcare professionals. Please use this page to record visits to specialists such as: Rheumatologists, Pulmonologists, Cardiologists, Gastroenterologists, Dermatologists, Nephrologists, Vascular Surgeons, etc.

Date	Name / Type of Doctor	Reason for Visit	Diagnosis	Recommended Treatmen

Comments		

Specialist Visits - Cont.

Date	Name / Type of Doctor	Reason for Visit	Diagnosis	Recommended Treatment
		V		

Comments			

Legal Documents (originals)

	Living Will – A document where the patient can describe any life-sustaining treatment he/she may want prior to the patient being unable to make these decisions.				
	Health Care Power of Attorney – This is a legal document where the patient gives another person the power to make decisions about the patient's medical care if the patient is no longer able to communicate.				
	Do Not Resuscitate form – Intended to help people in the final stages of terminal illness or who suffer from a serious condition. They inform healthcare professionals to forgo resuscitation attempts such as, CPR, intubation, defibrillation, administration of certain drugs, etc.				
	DNR (Do Not Resuscitate) Directive – A form requested by the patient that extraordinary measures are not to be used.				
	DNR Order – a physician's order on the chart stating that extraordinary measures are not to be used in an attempt to save a patient's life.				
	Birth Certificate				
	Release(s) for Medical Information				
state	It is highly recommended that you check with an attorney in your state to learn about required documents as these requirements may vary from state to state.				