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.

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MEDICAL HISTORY TEMPLATE

Name: ____________________________ Blood Type: _______ Positive  Negative

<table>
<thead>
<tr>
<th>Date</th>
<th>Medical Condition/Surgery/Injury</th>
<th>Comments</th>
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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

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


*This guide does not replace legal council. Consult with a lawyer for all questions and/or concerns.*
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:
____________________________________________________________________________
____________________________________________________________________________
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____________________________________________________________________________
# FINDING A REHABILITATION (REHAB) PROGRAM CHECKLIST

**Name of Program:** ____________________________________________________________

<table>
<thead>
<tr>
<th>About The Program</th>
<th>Yes</th>
<th>No</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does the program have a full-time physiatrist or other healthcare professional who is experienced in stroke and rehab medicine on staff?</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Does the program provide a wide range of therapy services? (Physical therapy, occupational therapy or speech therapy)</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Does the program provide the specific services the stroke survivor needs?</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Does the program have a formal system for evaluating the progress made by its patients and the overall outcomes of the stroke rehab program?</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>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)</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Are staff members required to keep up with new information about stroke and rehab? How do they do so?</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Does the program match the stroke survivor’s abilities, or is it too demanding or not demanding enough?</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Is medical care available at the rehab center if needed?</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Question</td>
<td>Yes</td>
<td>No</td>
<td>Notes</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>Can the stroke survivor’s healthcare professional visit him/her at the rehab center?</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Does the program have a stroke support group for survivors and their families? If not, can they make a referral to a local group?</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Does the program use outside groups (such as consumer advocacy groups) to get ideas for serving people with disabilities?</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Does the program conduct home visits before checking people out of the center and releasing them to their homes?</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Has the program been in operation at least one year?</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TREATMENTS &amp; SERVICES</th>
<th>Yes</th>
<th>No</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does the program provide the specific services the stroke survivor needs?</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Is the stroke survivor eligible for those treatments?</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Will there be bilingual staff members?</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Will there be sign language interpreters?</td>
<td>☐</td>
<td>☐</td>
<td></td>
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<tr>
<td>Will medical information be explained in simple terms?</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Is help available with discharge? How does it work?</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>What percentage of people will return home after discharge?</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>What percentage of people will be placed in nursing homes?</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>LOCATION</td>
<td>Yes</td>
<td>No</td>
<td>Notes</td>
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<tr>
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<tr>
<td>If it is an outpatient program, is transportation available?</td>
<td>☐</td>
<td>☐</td>
<td></td>
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<tr>
<td>Is the location convenient?</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Is the location close to public transportation?</td>
<td>☐</td>
<td>☐</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>HOURS</th>
<th>Yes</th>
<th>No</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are the days and times convenient for the stroke survivor?</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>What are the visiting hours?</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Are the visiting hours convenient for family and friends?</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Are the visiting hours long enough for a good quality visit?</td>
<td>☐</td>
<td>☐</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>COST &amp; INSURANCE</th>
<th>Yes</th>
<th>No</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the estimated cost of treatment?</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Will the stroke survivor’s insurance plan or government funding (Medicare, Medicaid, state health plans) cover all or part of the cost?</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Will the staff help with health insurance claims or appeals, if needed?</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>What is the average total cost for the complete stroke program? (Acute rehabilitation, home care and outpatient)</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>CUSTOMER SERVICE &amp; SATISFACTION</td>
<td>Yes</td>
<td>No</td>
<td>Notes</td>
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<tr>
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<tr>
<td>Does the program collect information from patients and their families about satisfaction with the care received?</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>If so, is the feedback generally positive?</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Can I talk to other people who have used the services?</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>How long do most stroke survivors stay in the program?</td>
<td>N/A</td>
<td>N/A</td>
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Notes:
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# MEDICATION TRACKER TEMPLATE

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

<table>
<thead>
<tr>
<th>Medications</th>
<th>Dosage</th>
<th>Morning</th>
<th>Noon</th>
<th>Afternoon</th>
<th>Night</th>
<th>How Does the Med Make You Feel?</th>
<th>Date of Last Med/Dose Change</th>
<th>Comments</th>
<th>Date of Next Refill</th>
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<tbody>
<tr>
<td>SAMPLE</td>
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<td>#1= Baclofen</td>
<td>10mg</td>
<td>X</td>
<td>X</td>
<td></td>
<td>X</td>
<td></td>
<td>12-2011</td>
<td>For spasticity</td>
<td>2-2012</td>
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Patient Name: ____________________________________________________________

Primary Care Provider: ______________________________________ Phone: ____________________________

Pharmacy: ___________________________________________ Phone: ____________________________

Medication Allergies: ____________________________________________________________

Food Allergies: ____________________________________________________________
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: __________________________________________________________
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.

1-800-STROKES
(787-6537)
www.stroke.org

This guide is supported through grants from Genentech and Metlife Foundation. All publications are reviewed by National Stroke Association’s Publications Committee.

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3/12 EZ11