PATIENT CONTACT INFORMATION

Name ____

Address____

City __________________ State________ Zip ________________

Phone Number ___________________ Email _________________

CAREGIVER CONTACT INFORMATION (if applicable)

Name ____

Address____

City __________________ State________ Zip ________________

Phone Number ___________________ Email _________________

EMERGENCY CONTACT INFORMATION

Name ____

Phone Number ___________________ Email _________________

Primary Physician Name_______________________________

Primary Physician Phone Number_________________________

Hospital to be transported to in an emergency_______________

ADDITIONAL PATIENT INFORMATION

Cancer type _______________________ Year diagnosed___________

In hospice care? Yes No

Physical limitations? Yes No
If yes, please describe:

____

(important in case people want to help with transportation, outings, etc.)

Nutritional requirements, allergies, etc.? Yes No
If yes, please describe:

____

(important in case people want to provide meals)

Are there children in the home? Yes No
If yes, please list name and age below:

Name________________ Age_____ Name ______________ Age ______

Name________________ Age_____ Name ______________ Age ______

(you may want to provide some assistance or care to them)

Pets in the house? Yes No *(In case lay minister is allergic or fearful of dogs, etc.)*

Transportation assistance needed? Yes No
If yes, please describe:

____

(important in case people want to provide meals)

Living will or advance directive completed? Yes No
If yes, did patient provide church with a copy? Yes No

Patient Information Checklist

Please describe any other special concerns or needs?

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Additional comments:

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