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

OUR JOURNEY of HOPE®

Patient Information Checklist

Please describe any other special concerns or needs?

_____

_____

_____

_____

_____

Additional comments:

_____

_____

_____

_____

_____