Portable Health Profile Tool Template

Kennedy Krieger Institute's Portable Health Profile Tool (PHPT) template:

- Helps ensure a patient will have their healthcare information with them when they visit a clinician or seek emergency medical services
- Empowers patients to be responsible for their own care
- Includes text boxes for writing in basic health and emergency contact information
- Includes text boxes for information that is confidential, and which may be privileged or exempt from disclosure under applicable law

1. Personal information:

Name			**Date**
Street Address	**City**	**State**	**ZIP**
Home Phone	**Mobile Phone**	**Work Phone**	
Date of Birth (mm/dd/yyyy)	**Blood Type**		
Race	**Ethnicity**	**Language Preferred**	
Sex	**Gender Identity**		

2. Emergency contact(s):

Name	**Relationship**	
Street Address	**City, State**	**ZIP**
Home Phone	**Mobile Phone**	

Name	**Relationship**	
Street Address	**City, State**	**ZIP**
Home Phone	**Mobile Phone**	

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3. Known medical conditions/diagnoses *(check all that apply)*:

Medical Condition/Diagnosis			
☐	**Autism Spectrum Disorder**	☐	**Lung Disease**
☐	**Behavioral Disorder**	☐	**Prematurity/Developmental Delay**
☐	**Blood Disorder**	☐	**Seizures/Epilepsy**
☐	**Cancer—Type: _____**	☐	**Spinal Cord Injury**
☐	**Hearing Impairment**	☐	**Stroke/Transient Ischemic Attack (TIA)**
☐	**Heart Disease**	☐	**Traumatic Brain Injury**
☐	**Kidney Disease**	☐	**Visual impairment**
☐	**Liver Disease**	☐	**Mental Health Conditions** (e.g., depression, anxiety, bipolar disorder, suicidality, etc.)
☐	**Other *(please describe)*:**		

4. Surgeries and hospitalizations:

Type of Surgery/Reason for Hospitalization	**Date** (mm/dd/yyyy)

5. Medications:

Medication	**Dosage**	**Frequency**	**Date Started** (mm/dd/yyyy)	**Date Stopped** (mm/dd/yyyy)	**Prescribing Clinician's Name and Phone Number**

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Over-the-Counter Vitamins/Supplements	**Dosage**	**Frequency**	**Date Started** (mm/dd/yyyy)	**Date Stopped** (mm/dd/yyyy)	**Recommending Clinician** (if applicable)

6. Devices (e.g., prosthesis, CPAP, BiPAP, pacemaker, wheelchair, insulin pumps, hearing aids, durable medical equipment, etc.):

Device	**Provider/Vendor**	**Provider/Vendor Contact Number**	**Date Obtained/ Date of Last Service**

7. Known allergies (e.g., to medications, food or environmental factors):

8. Family health history:

Medical Condition/Diagnosis	**Relationship to Patient**

9. Special needs:

Mobility	
Sensory	
Communication	
Developmental	
Toileting	
Feeding/Nutrition	
Other	

10. Immunizations:

Resource: https://www.cdc.gov/vaccines/schedules/downloads/child/0-18yrs-child-combined-schedule.pdf

Name	**Date(s) Administered**
Influenza (Flu)	
Pneumonia	
Diphtheria, Tetanus and Pertussis (Dtap/Tdap)	
Chicken Pox	
Human Papillomavirus (HPV)	
Hepatitis B Series	
Measles Mumps Rubella (MMR) Series	
COVID-19	
Other	
Other	
Other	

11. Preferred clinicians:

Primary Care Provider	**Phone Number**	
Street Address	**City/State**	**ZIP**

Dentist	**Phone Number**	
Street Address	**City, State**	**ZIP**

Specialist 1	**Specialty**	**Phone Number**
Street Address	**City, State**	**ZIP**

Specialist 2	**Specialty**	**Phone Number**
Street Address	**City, State**	**ZIP**

Specialist 3	**Specialty**	**Phone Number**
Street Address	**City, State**	**ZIP**

12. Community providers:

Care Manager		**Phone Number**
Street Address	**City, State**	**ZIP**

Service Coordinator Agency		**Phone Number**
Street Address	**City, State**	**ZIP**

Home Health Agency		**Phone Number**
Street Address	**City, State**	**ZIP**

Nurse Agency		**Phone Number**
Street Address	**City, State**	**ZIP**

13. Preferred hospitals:

Name		**Phone Number**
Street Address	**City, State**	**ZIP**

Name		**Phone Number**
Street Address	**City, State**	**ZIP**

14. Preferred pharmacy:

Name		**Phone Number**
Street Address	**City, State**	**ZIP**

15. Health insurance information:

Primary health insurance provider type: ☐Private ☐Medicare ☐Medicaid ☐Other

Name		**Phone Number**
ID Number		
Group Name		**Group Number**
Subscriber Name		
Subscriber Number/ID Number		
Subscriber Street Address	**City, State**	**ZIP**

Secondary health insurance provider type: ☐Private ☐Medicare ☐Medicaid ☐Other

Name		**Phone Number**
ID Number		
Group Name		**Group Number**
Subscriber Name		
Subscriber Number/ID Number		
Subscriber Street Address	**City, State**	**ZIP**

16. Living will/medical orders for life-sustaining treatment (MOLST) information (i.e., advance directives—for individuals 18 years of age or older):

Have you signed a living will or advance directive? ☐Yes ☐No

If yes, what is the location of your living will or advance directive?

17. Power of attorney:

Name		**Relationship**	
Street Address		**City, State**	**ZIP**
Home Phone	**Work Phone**	**Mobile Phone**	