VITAL RECORDS LOG

A Record-Keeping and Personal Care Guide

About the Vital Records Log

The Vital Records Log gives users an easy way to record the information they need to interact with physicians, hospital records personnel, therapists, insurance firms, federal, state and local agencies and organizations, direct support professionals, and all other professional and personal support personnel needed to provide the appropriate care for a patient with a developmental disability or chronic illness. Pages from the printed guide can be easily copied. In addition, the guide is available in an easy-to-print PDF document at GCDD.ark.org.

Note: This guide is not intended to cover every circumstance in which recording vital information may be needed.

TABLE OF CONTENTS

Vital Records Section

Personal Care Guide

KEEPING VITAL RECORDS IS AN ESSENTIAL CHORE

Nothing is more important to the welfare of the patient than developing and maintaining a complete, up-to-date record.

Record-keeping is essential to the patient's welfare. It's important for emergency hospital visits, insurance claims, and respite care providers, or for documenting events and/or contacts about medical needs. There is no other way to be prepared for events where current information is needed. Like it or not, understand it or not, there are forms you have to fill out everywhere you go! Having the basic information on hand makes it bearable. It's also a way of noting family history, when developmental landmarks are met and the next logical steps, all of which may help identify delays or detect problems.

Personal, Medical & Insurance Information

Below is a list of some of the important information that *must* be kept. It is *not* a complete list – that depends entirely on the patient's disability or chronic illness. You may also decide to keep this information for other members of your family. This includes such personally identifiable information as:

Personal

- Birth certificates
- Parent or guardian information
- Location and/or copies of wills and/or trusts
- Daily care schedule
- Emergency contacts, including e-mail and cell phone number

Medical

- Initial diagnosis
- Health history
- Physicians and other medical specialists
- Medication and seizure logs
- Daily care schedule
- Immunization records
- Office visits
- Hospitalizations log
- Emergency contacts

Insurance

- Health and life insurance information

Medical Bills & Insurance Claims

Keep *all* information needed to fill out forms if you must request reimbursement. Otherwise, keep the "explanation of benefits" forms that you will receive after the claim is filed by your medical professional. Maintain files on all insurance company correspondence or claims. For tax purposes, keep an accurate account of what your policy covered and your out-of-pocket expenses.

Evaluations, Reports & Records

Keep copies or records of all correspondence (written and verbal) with service providers, medical support specialists and other professionals, along with all reports, records and other documents. They may contain important information in those cases where discrepancies may arise concerning your patient's needs. Be certain copies of all medical reports are sent to your patient's physicians.

Getting Organized

How your record-keeping system is organized is up to you. Just be certain it allows quick, easy access to *all* the information needed under any circumstance. Here are some recommendations:

If you are keeping paper records, purchase a three-ring binder with pockets for organizing and holding reports, etc. Insert blank pages and/or forms for recording your own information. Keep all current information in the notebook. Keep older information in a permanent, but portable, filing system. Purchase a small, portable file and file folders. File information using separate file folders for each category. To prevent record-keeping from becoming a chore that keeps you from spending time with the important people in your life, organize early and in a manner that best suits your family's individual needs. If you have the capability, scanning and filing your documentation in an electronic file on a computer will allow you to easily have access.

PERSONAL MEDICAL INFORMATION

Personal Information

Patient's Name: _____ Age: _____ Date of Birth: _____

Birthplace: _____ Sex: ☐ M ☐ F SSN: _____

Address: _____

City: _____ State: _____ ZIP: _____

Mother/Legal Guardian: _____ SSN: _____

Address (if different): _____

City: _____ State: _____ ZIP: _____

Home Phone: _____ E-mail: _____

Work Phone: _____ Cell Phone: _____

Father/Legal Guardian: _____ SSN: _____

Address (if different): _____

City: _____ State: _____ ZIP: _____

Home Phone: _____ E-mail: _____

Work Phone: _____ Cell Phone: _____

Emergency Contact(s): _____

Relationship: _____ E-mail: _____

Cell Phone: _____ Home Phone: _____

HEALTH HISTORY

Initial Diagnosis: _____

Diagnosis Date: _____

Other Medical Conditions/Information: _____

Family Physician: _____

Office Address: _____

City: _____ State: _____ ZIP: _____

Office Phone: _____

E-mail: _____

Website: _____

Allergies: _____

Medications: _____

Assistive Devices: _____

Vision and/or Hearing Devices: _____

Other Medical Specialist: _____

Office Address: _____

City: _____ State: _____ ZIP: _____

Office Phone: _____

E-mail: _____

Website: _____

Other Medical Specialist: _____

Office Address: _____

City: _____ State: _____ ZIP: _____

Office Phone: _____

E-mail: _____

Website: _____

Notes:

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TESTS & EVALUATIONS

Conducted By:_____ Date Conducted: _____
Office Phone:_____ Office Fax: _____
Evaluation/Test Results:

_____

_____

Conducted By:_____ Date Conducted: _____
Office Phone:_____ Office Fax: _____
Evaluation/Test Results:

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Evaluation/Test Results:

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Conducted By:_____ Date Conducted: _____
Office Phone:_____ Office Fax: _____
Evaluation/Test Results:

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Notes:

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MEDICAL OFFICE VISITS

Accompanied By:_____ Date: _____
Reason for Visit: _____ Physician/Specialist:_____
Clinic Name:_____ Address:_____
Phone Number: _____ Fax Number:_____
E-mail:_____ Website: _____
Tests Performed:_____
Results & Treatment:

_____
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Followup Instructions:_____
Notes:

_____
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_____

Accompanied By:_____ Date: _____
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Phone Number: _____ Fax Number:_____
E-mail:_____ Website: _____
Tests Performed:_____
Results & Treatment:

_____
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Followup Instructions:_____
Notes:

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_____

HOSPITALIZATIONS

Accompanied By: ______________________________ Date of Admittance: ______________________
Reason: ____
Specialized Tests Performed: ____
Results & Treatments: ____
Followup Instructions: ____
Attending Physician and/or Surgeon: ____
Date of Discharge: ____________________________ Hospital Name: _________________________
Address: ____________________________________ Phone Number: _________________________
Notes:
____
____

Accompanied By: ______________________________ Date of Admittance: ______________________
Reason: ____
Specialized Tests Performed: ____
Results & Treatments: ____
Followup Instructions: ____
Attending Physician and/or Surgeon: ____
Date of Discharge: ____________________________ Hospital Name: _________________________
Address: ____________________________________ Phone Number: _________________________
Notes:
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Reason: ____
Specialized Tests Performed: ____
Results & Treatments: ____
Followup Instructions: ____
Attending Physician and/or Surgeon: ____
Date of Discharge: ____________________________ Hospital Name: _________________________
Address: ____________________________________ Phone Number: _________________________
Notes:
____
____

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Results & Treatments: ______________________
Followup Instructions: ______________________
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Address: ______________________ Phone Number: ______________________
Notes:

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Reason: ______________________
Specialized Tests Performed: ______________________
Results & Treatments: ______________________
Followup Instructions: ______________________
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Address: ______________________ Phone Number: ______________________
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Reason: ______________________
Specialized Tests Performed: ______________________
Results & Treatments: ______________________
Followup Instructions: ______________________
Attending Physician and/or Surgeon: ______________________
Date of Discharge: ______________________ Hospital Name: ______________________
Address: ______________________ Phone Number: ______________________
Notes:

____

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MEDICATIONS

Date Prescribed or Changed	Medication Name and Dosage	Prescribed By	Doctor's Special Instructions	Pharmacy and Phone Number	Date Discontinued	Reason Discontinued

MEDICAL EXPENSES
(Personal Payments Record)

Date of Service: _____
Service Performed: _____
Agency/Provider: _____
Contact Name for Billing Concerns: _____
Address: _____
Phone Number: _____
Total Cost: _____ Insurance Paid: _____
Direct and Associated Costs Not Covered: _____
Payment Arrangements: _____
Date: _____ Check Number: _____ Payment Amount: _____ Balance Owed: _____
Date: _____ Check Number: _____ Payment Amount: _____ Balance Owed: _____
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Notes:

_____

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Date: _____ Check Number: _____ Payment Amount: _____ Balance Owed: _____
Notes:

_____

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_____

INSURANCE CLAIMS

Insurance Company Information

Primary Insurance Carrier:

Office Address: _____

City: _____ State: _____ ZIP: _____

Phone Number: _____ Fax Number: _____

E-mail: _____ Website: _____

Policy Number: _____ Group Number: _____

Agent's Name: _____

Agent's Address: _____

City: _____ State: _____ ZIP: _____

Phone/Fax/E-mail: _____

Secondary Insurance Carrier:

Office Address: _____

City: _____ State: _____ ZIP: _____

Phone Number: _____ Fax Number: _____

E-mail: _____ Website: _____

Policy Number: _____ Group Number: _____

Agent's Name: _____

Agent's Address: _____

City: _____ State: _____ ZIP: _____

Phone/Fax/E-mail: _____

Medicaid Number: _____

State: _____ Date of Eligibility: _____

Policyholder Information

Name: _____

Address: _____

City: _____ State: _____ ZIP: _____

Home Phone Number: _____ Cell Phone Number: _____

Date of Birth: _____ SSN: _____

Relationship to Patient: _____

Other Important Information

Pre-existing conditions not covered, waivers or riders attached to the policy, cost-share information, etc:

_____

_____

MEDICAL INSURANCE SUMMARY

Family Member: _____ Year: _____ Page Number: _____

Date of Visit	Billed From	Billed For	Amount Billed	Amount Paid at Visit

Date Payment Mailed to Insurance Company	How Insurance Company Handled the Charges	Amount Not Paid by Insurance Company	Date All Charges Paid in Full

COMMUNITY RESOURCES

Agencies and Organizations

Community Services (Nonprofit): _____

Name of Agency/Organization: _____

Office Address: _____

City: _____ State: _____ ZIP: _____

Phone Number: _____ Fax Number: _____

E-mail: _____ Website: _____

Contact Person: _____

Description of Services: _____

Name of Agency/Organization: _____

Office Address: _____

City: _____ State: _____ ZIP: _____

Phone Number: _____ Fax Number: _____

E-mail: _____ Website: _____

Contact Person: _____

Description of Services: _____

County Services: _____

Name of Agency/Organization: _____

Office Address: _____

City: _____ State: _____ ZIP: _____

Phone Number: _____ Fax Number: _____

E-mail: _____ Website: _____

Contact Person: _____

Description of Services: _____

Name of Agency/Organization: _____

Office Address: _____

City: _____ State: _____ ZIP: _____

Phone Number: _____ Fax Number: _____

E-mail: _____ Website: _____

Contact Person: _____

Description of Services: _____

State Agency/Organization: _____

Name of Agency/Organization: _____

Office Address: _____

City: _____ State: _____ ZIP: _____

Phone Number: _____ Fax Number: _____

E-mail: _____ Website: _____

Contact Person: _____

Description of Services: _____

Name of Agency/Organization: _____

Office Address: _____

City: _____ State: _____ ZIP: _____

Phone Number: _____ Fax Number: _____

E-mail: _____ Website: _____

Contact Person: _____

Description of Services: _____

Federal Agency/Organization: _____

Name of Agency/Organization: _____

Office Address: _____

City: _____ State: _____ ZIP: _____

Phone Number: _____ Fax Number: _____

E-mail: _____ Website: _____

Contact Person: _____

Description of Services: _____

Name of Agency/Organization: _____

Office Address: _____

City: _____ State: _____ ZIP: _____

Phone Number: _____ Fax Number: _____

E-mail: _____ Website: _____

Contact Person: _____

Description of Services: _____

Notes:

_____

_____

AGENCY/PROVIDER CONTACT

Organization: ____________________
Name of Person: ____________________
Phone Number: ____________________ E-mail: ____________________
Date Contacted: ____________________ Time: __________ ☐ a.m. ☐ p.m.
☐ I Contacted Them ☐ They Contacted Me
Reason for Discussion:

____
Answers and/or Results:

____
Action(s) to be Taken:

____

Organization: ____________________
Name of Person: ____________________
Phone Number: ____________________ E-mail: ____________________
Date Contacted: ____________________ Time: __________ ☐ a.m. ☐ p.m.
☐ I Contacted Them ☐ They Contacted Me
Reason for Discussion:

____
Answers and/or Results:

____
Action(s) to be Taken:

____

Organization: ____________________
Name of Person: ____________________
Phone Number: ____________________ E-mail: ____________________
Date Contacted: ____________________ Time: __________ ☐ a.m. ☐ p.m.
☐ I Contacted Them ☐ They Contacted Me
Reason for Discussion:

____
Answers and/or Results:

____
Action(s) to be Taken:

____

ADDITIONAL AGENCY/PROVIDER CONTACTS

Organization Name and Address	Phone Number(s)	Organization Name and Address	Phone Number(s)

PERSONAL CARE GUIDE

Personal Information – The Family and Other Important People

Patient's Name: _____ Age: _____

Comfort Item/Toy: _____ Favorite Activity: _____

Please include any information that would benefit a caregiver who is not familiar with the patient:

_____

_____

_____

_____

_____

_____

Note: Personal care, respite and proper provider support depend on the parents/guardians furnishing the information needed to give the patient appropriate care.

Emergency Contacts

Police, Fire and Ambulance – 911

Has family registered for Smart 911? ☐ Y ☐ N

Poison Control Center: _____

Phone: _____

Family Physician: _____

Phone: _____

Pharmacy: _____

Phone: _____

Insurance Agency: _____

Contact Person: _____

Phone: _____

Employer: _____

Contact Person: _____

Phone: _____

Preferred Hospital: _____

Contact Person: _____

Phone: _____

Household Information

First Aid Location:

_____

Who, if anyone, is allowed to visit the patient when the primary caregiver isn't home?

_____

_____

Can the patient be outside? ☐ Y ☐ N

If so, explain the boundaries, rules and length of time:

_____

_____

_____

Household rules caregivers should follow when the primary caregiver is not with the patient:

_____

_____

_____

_____

_____

_____

_____

DAILY SCHEDULE

7:00 a.m.

8:00 a.m.

9:00 a.m.

10:00 a.m.

11:00 a.m.

Noon

1:00 p.m.

2:00 p.m.

3:00 p.m.

4:00 p.m.

5:00 p.m.

6:00 p.m.

7:00 p.m.

8:00 p.m.

9:00 p.m.

10:00 p.m.

11:00 p.m.

Midnight

1:00 a.m.

2:00 a.m.

3:00 a.m.

4:00 a.m.

5:00 a.m.

6:00 a.m.

Notes:

SEIZURES

Does the patient have seizures? ☐ Y ☐ N
If so, describe in detail:

_____
_____
_____

General length of seizures: _____

What procedure(s) should be followed during a seizure?

_____
_____
_____

Do you want the paramedics to be called? ☐ Y ☐ N

Should the seizures be recorded? ☐ Y ☐ N

What usually occurs following a seizure? (Will the patient become sleepy, cranky, etc.?)

_____
_____
_____

Notes:

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_____
_____
_____
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_____

DAILY MEDICATIONS

This section is for information purposes. Dosage and medication changes should be updated as needed.

Medication: ______________________ Dosage: ______________________
Time To Be Given: ______________________ Time Given: ______________________
Prescribing Doctor: ______________________ Emergency Phone: ______________________

Medication: ______________________ Dosage: ______________________
Time To Be Given: ______________________ Time Given: ______________________
Prescribing Doctor: ______________________ Emergency Phone: ______________________

Medication: ______________________ Dosage: ______________________
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Medication: ______________________ Dosage: ______________________
Time To Be Given:: ______________________ Time Given: ______________________
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Medication: ______________________ Dosage: ______________________
Time To Be Given: ______________________ Time Given: ______________________
Prescribing Doctor: ______________________ Emergency Phone: ______________________

Medication: ______________________ Dosage: ______________________
Time To Be Given: ______________________ Time Given: ______________________
Prescribing Doctor: ______________________ Emergency Phone: ______________________

COMMUNICATING WITH THE PATIENT

Is the patient verbal? ☐ Y ☐ N Does the patient use American Sign Language? ☐ Y ☐ N

If the patient is not verbal, how does he/she communicate?

Does the patient use hand signals as a form of communication? ☐ Y ☐ N

If so, describe:

Specifically, how does the patient communicate the need to eat?

Ask to be picked up or held?

Express interest in having a specific item given to them?

How does the patient communicate a specific interest in a particular activity?

Notes:

HOW DOES THE PATIENT COMMUNICATE THE FOLLOWING?

Hungry

Thirsty

Tired

Happy

Hot

Cold

Brother

Sister

Mother

Father

Blanket

Bath

Toilet

Diaper

Bed

Dog

Cat

Video

TV

Music

Hello

Goodbye

Car

Walk

Outside

Inside

Sad

Angry

Play with me

Leave me alone

I want more

I am finished

Please

Thank you

I'm sick

Additional information needed to better understand the patient's communication:

Does the patient use a specialized communication device? ☐ Y ☐ N
If so, describe:

Where is it located and/or placed when not in use?

Notes:

BEHAVIOR

Describe the patient's normal temperament:

Are there behaviors that are particularly challenging? ☐ Y ☐ N
If so, what actions should be taken?

Is there a specific behavior plan for the patient? If so, please describe:

Has the patient been known to wander or run away? ☐ Y ☐ N
If so, what actions should be taken:

Activities that make the patient content/happy, including games, favorite items, etc.;

Notes:

DIET & NUTRITION

What foods does the patient like?

What foods does the patient dislike?

What are the patient's favorite foods?

Does the patient have any food allergies? ☐ Y ☐ N
If so, list them and identify symptoms:

Does the patient swallow well? ☐ Y ☐ N
Chew well? ☐ Y ☐ N
Additional information:

Does the patient need assistance while eating? ☐ Y ☐ N
If yes, describe assistance:

Is there a particular position or adaptive equipment necessary to assist the patient during the meal?

Detail the location of the patient's food, eating utensils and/or adaptive equipment:

Notes:

BED & NAP TIMES

At what time does the patient go to bed? _____

What are the patient's nap time(s)? _____

Does the patient sleep alone? ☐ Y ☐ N

Is the patient afraid of the dark? ☐ Y ☐ N

What special blanket, stuffed animal, etc., does the patient like to sleep with?

_____

_____

_____

Describe special positioning needs at bedtime:

_____

_____

_____

Describe nightly routine:

_____

_____

_____

Does the patient usually sleep through the night? ☐ Y ☐ N
If not, explain the activities required to either induce sleep or keep the patient occupied while awake:

_____

_____

_____

Notes:

_____

_____

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_____

PERSONAL HYGIENE

Does the patient use the toilet? ☐ Y ☐ N

Can he/she use the toilet alone? ☐ Y ☐ N
If not, describe the special assistance required:

_____

_____

Does the patient require diapers? ☐ Y ☐ N
Training pants? ☐ Y ☐ N
A potty chair? ☐ Y ☐ N

Can the patient brush his/her own teeth? ☐ Y ☐ N
If yes, explain how:

_____

_____

Can the patient dress himself/herself? ☐ Y ☐ N
If yes, what assistance is necessary?

_____

_____

Can the patient bathe himself/herself? ☐ Y ☐ N
Is adaptive equipment required? ☐ Y ☐ N
If yes, explain how the equipment is used:

_____

_____

Notes:

_____

_____

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_____

_____

_____

Inclusion. Integration. Independence.

We envision a world where everyone has an equal and real opportunity to lead a meaningful and productive life!

Governor's Council on
Developmental Disabilities
inclusion. integration. independence.

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