



|   |                       |                             |                     |                          |                  |
|---|-----------------------|-----------------------------|---------------------|--------------------------|------------------|
| Date Completed:   |                       | Date Revised:               |                     |                          |                  |
| Form completed by:  |                       |                             |                     |                          |                  |
| <b>Contact Information</b>  |                       |                             |                     |                          |                  |
| Name:   |                       |                             | Nickname:           |                          |                  |
| DOB:  |                       |                             | Preferred Language: |                          |                  |
| Address:  |                       |                             |                     |                          |                  |
| Cell #:   |                       | Home #:                     |                     | Best Time to Reach:      |                  |
| Email:  |                       |                             | Best Way to Reach:  |                          | Text Phone Email |
| Health Insurance Plan:  |                       |                             | Group and ID #:     |                          |                  |
| Cardiologist (1):   |                       | Location:                   |                     | Phone:                   |                  |
| Cardiologist (2):   |                       | Location:                   |                     | Phone:                   |                  |
| <b>Emergency Care Plan</b>  |                       |                             |                     |                          |                  |
| Emergency Contact:  |                       | Relationship:               |                     | Phone:                   |                  |
| Preferred Emergency Care Location:  |                       |                             |                     |                          |                  |
| Procedural Antibiotics Recommended (Endocarditis Prophylaxis): <input type="checkbox"/> Yes <input type="checkbox"/> No |                       |                             |                     |                          |                  |
| Common Emergent Presenting Problems   |                       | Suggested Tests             |                     | Treatment Considerations |                  |
|   |                       |                             |                     |                          |                  |
| Special Considerations:   |                       |                             |                     |                          |                  |
| <b>Allergies</b>  |                       |                             |                     |                          |                  |
| Allergies   |                       |                             | Reactions           |                          |                  |
|   |                       |                             |                     |                          |                  |
| <b>Diagnosis and Current Problems</b>   |                       |                             |                     |                          |                  |
| Problem   |                       | Details and Recommendations |                     |                          |                  |
| Primary Cardiac Diagnosis:  |                       |                             |                     |                          |                  |
| Secondary Diagnoses:  |                       |                             |                     |                          |                  |
| <input type="checkbox"/> Pulmonary  |                       |                             |                     |                          |                  |
| <input type="checkbox"/> Renal  |                       |                             |                     |                          |                  |
| <input type="checkbox"/> Liver  |                       |                             |                     |                          |                  |
| <input type="checkbox"/> Neuro-developmental  |                       |                             |                     |                          |                  |
| <input type="checkbox"/> Genetic  |                       |                             |                     |                          |                  |
| <input type="checkbox"/> Contraception  |                       |                             |                     |                          |                  |
| <input type="checkbox"/> Hematologic/Anticoagulation  |                       |                             |                     |                          |                  |
| <input type="checkbox"/> Psychologic  |                       |                             |                     |                          |                  |
| <input type="checkbox"/> Other  |                       |                             |                     |                          |                  |
| <b>Medications</b>  |                       |                             |                     |                          |                  |
| Medications   |                       | Dose                        | Frequency           | Medications              |                  |
|   |                       |                             |                     |                          |                  |
|   |                       |                             |                     |                          |                  |
| <b>Activity Restrictions</b>  |                       |                             |                     |                          |                  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No  |                       | Details:                    |                     |                          |                  |
| <b>Other Health Care Providers</b>  |                       |                             |                     |                          |                  |
| Provider  | Primary and Specialty |                             | Clinic or Hospital  | Phone                    | Fax              |
|   |                       |                             |                     |                          |                  |
|   |                       |                             |                     |                          |                  |
|   |                       |                             |                     |                          |                  |