NORTHEAST REHABILITATION HOSPITAL NETWORK
70 BUTLER STREET • SALEM, NEW HAMPSHIRE 03079
(603) 893-2900 FAX (603) 893-1628
www.northeastrehab.com

UPDATED: April 17, 2014

NORTHEAST REHABILITATION HOSPITAL PORTABLE PATIENT PROFILE

The purpose of this form is to aid you in identifying you and your medical history to other health care providers or emergency personnel

PATIENT INFORMATION

Name: _____ Date of Birth: _____

Address: _____ Language: _____ Religion: _____

City, State, Zip: _____ Primary Insurance: _____

Phone: _____ ☐ Home ☐ Work ☐ Cell Policy Number: _____

Phone: _____ ☐ Home ☐ Work ☐ Cell Preferred Hospital: _____

Do You Have Advanced Directive? ☐ Yes ☐ No

(If Yes, please attach a copy of this form)

Do you have a guardian? ☐ Yes ☐ No

Name _____

EMERGENCY CONTACTS

Name: _____ Name: _____

Address: _____ Address: _____

City, State, Zip: _____ City, State Zip: _____

Phone: _____ ☐ Home ☐ Work ☐ Other Phone: _____ ☐ Home ☐ Work ☐ Other

PHYSICIANS INVOLVED IN MY CARE

Specialty: _____ Phone: _____

NRH Attending: _____ Phone: _____

Primary Care: _____ Phone: _____

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PLEASE LIST ALL KNOWN ALLERGIES

_____

_____

_____

Immunizations Up to Date: ☐ Yes ☐ No

Date of Last Flu Vaccine: _____

Date of Last Pneumonia Vaccine: _____

Functional Status: ☐ Independent ☐ Needs Assistance

Current Pain Level at Discharge _____/10

Vitals at Discharge BP ____/___ HR _____ RR _____ Temp _____° F

Do you use tobacco? ☐ Yes ☐ No Number of packs per day: _____

I formerly smoked/used tobacco, but quit (list year): _____

Do you drink alcohol? ☐ Yes ☐ No How Frequently/How Much? _____

Do you have difficulty swallowing?	☐ Yes ☐ No		
Do you wear contact lenses/glasses?	☐ Yes ☐ No		
Are you legally blind?	☐ Yes ☐ No	If Yes: ☐ RIGHT ☐ LEFT ☐ BOTH	
Do you wear dentures?	☐ Yes ☐ No	If Yes: ☐ RIGHT ☐ LEFT ☐ BOTH	
Do you have hearing impairment?	☐ Yes ☐ No	If Yes: ☐ RIGHT ☐ LEFT ☐ BOTH	
Do you have a cognitive impairment?	☐ Yes ☐ No		
Do you have communication impairment?	☐ Yes ☐ No	If Yes: ☐ RIGHT ☐ LEFT ☐ BOTH	

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DO YOU HAVE OR HAVE YOU EVER BEEN TREATED FOR THE FOLLOWING

Most Recent Hospitalization Date: _____ Reason: _____

Anemia	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Hypertension	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	High Cholesterol	☐ Yes	☐ No
Alcohol Problems	☐ Yes	☐ No	Jaundice	☐ Yes	☐ No
Bleeding Tendency	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No
Con Heart Defect	☐ Yes	☐ No	Leukemia	☐ Yes	☐ No
Depression	☐ Yes	☐ No	Lung Disease	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Lupus	☐ Yes	☐ No
Epilepsy	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No	Stroke/TIA	☐ Yes	☐ No
Heart Disease	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Heart Murmur	☐ Yes	☐ No	Thyroid Disease	☐ Yes	☐ No
			Ulcers	☐ Yes	☐ No

Please explain all Yes responses: _____

_____

_____

_____

Attached to the form you will find your discharge instructions which will address risk factors, signs, symptoms and your current medication list.