Medication Tracker: Keeping track of your medications helps keep you healthy.
Use this page to track all of your medications, include over-the-counter medications or supplements.

Name of Medication	What's it for?	Doctor	Dose	When to take it	How often	Notes or Concerns about Medication

Planning for My Future

What do your loved ones need to know?

A Question Prompt List (QPL) & Guide

This guide was prepared by: _____

Date of Birth: _____ / _____ / _____

Date this guide was prepared: _____ / _____ / _____

This program was funded through a Patient-Centered Outcomes Research Institute (PCORI) Eugene Washington PCORI Engagement Award (EADI #30051)

This document is intended to help you answer questions that you or your family may need to have answered in case of an unexpected life event. This is also good information to help you plan for post-surgery care. Feel free to add more notes and information.

Emergency Contacts

Contact Name _____
Relationship _____
Phone Number _____
Contact Name _____
Relationship _____
Phone Number _____
Contact Name _____
Relationship _____
Phone Number _____

Insurance

Health Insurance Company _____
Policy Number _____
Phone Number _____
Dental Insurance Company _____
Policy Number _____
Phone Number _____
Medicare/Medicaid Number _____
Life Insurance Company _____
Policy Number _____
Phone Number _____

I have a Long-Term Care Policy with

Company _____
Policy Number _____
Phone Number _____
Location _____
Terms (i.e. $ per day, length of policy) _____

Veteran Information

Military ID# / DoD# _____
Veterans Affairs Benefits _____
Veterans Affairs Facility/Hospital _____
Medical Records Location _____

My Blood Type: _____

Information about Pharmacies

Pharmacy #1 (local) _____
Pharmacy #2 *(mail order)* _____

Primary Care Provider

Provider Name _____
Clinic/Hospital _____
Contact Information _____

Legal Information

My Lawyer _____
Phone Number _____
My Power of Attorney _____
Phone Number _____
If I have a will/trust, it can be located _____
My Advanced Health Care Directive/Living Will is located _____
If I have a Do Not Resuscitate (DNR) Directive, it can be located _____
My health Power of Attorney _____
Phone Number _____
If I have a Do Not Resuscitate (DNR) Directive, it can be located _____

My financial information

Bank Name & Location _____
Credit Union Name & Location _____
CD / 401K Accounts & Locations _____

My trusted financial contact *(i.e. family member, broker, lawyer, etc.)*

Name of Person _____
Contact Information _____

If I have a payout from a former employer

Name of Company _____

Value of Payout _____

If I need subacute rehabilitation in a skilled nursing facility, I would like to go to:

Name of Place _____

Contact Information _____

If I need help in my home, I would like to use:

Name of Company _____

Contact Information _____

If I need low-cost help in my home, I would like this group to be contacted:

(i.e. a church, Grange, Lions Club, or similar organization)

Name of Company _____

Contact Information _____

If I need help in my home, I would like this group to be contacted

(i.e. an in-home health help company)

Name of Organization _____

Contact Information _____

People who might be able to help with:

Collecting my mail: _____

Picking up newspapers _____

Checking on bills to be paid _____

Driving for me: _____

Individual states or local governments have resources that can help people over the age of 65 in their area. I've chosen the following Area Agency on Aging if I need help with low-cost health in my home:

Name of Group _____

Contact Information _____

After surgery, am I willing to be placed on a ventilator to breathe for me?

Yes ____ No ____

If yes, how long am I willing to stay on the ventilator? _____

_____

After surgery, am I willing to have CPR or other life-saving measures taken?

Yes ____ No ____

After surgery, am I willing to have a feeding tube placed?

Yes ____ No ____

If yes, how long am I willing to stay on the tube? _____

_____

If there are life-threatening complications in surgery, I would prefer:

☐ Life-prolonging efforts to be taken.

☐ Comfort care only.

If I need in-home help with medical issues following surgery, I would prefer:

☐ A family member to help

☐ To have an outside organization/company help

☐ Other: _____

Friend or family who could help at home:

Name of Person _____

Contact Information _____

A caregiver, homemaker, or home health aid is sometimes needed to help with day-to-day activities.

If I need help in my home, I would like to use:

Name of Person/Organization _____

Contact Information _____

If I need physical therapy or rehabilitation, I would like to use:

Name of Person/Organization _____

Contact Information _____

What can I do to make my home safer? *(please check)*

- ☐ Attach the rug ends to the floor to keep them flat
- ☐ Remove any small rugs
- ☐ Try to move items that are often used to convenient spots
- ☐ Remove, or have carpeting with ridges and bubbles stretched
- ☐ Check any areas where you may stub your toe
- ☐ Install handrails in bathrooms; put nonslip strips or a rubber bath mat in the tub
- ☐ Identify thresholds between rooms that are elevated
- ☐ Ensure that there is sufficient lighting in all hallways, bathrooms, or other dark areas

If people are concerned about my driving: *(please check)*

- ☐ My physicians can be asked about my driving.
- ☐ I would like to have a younger loved one or friend drive with me once a month to check on my driving.
- ☐ I would like to be evaluated by a senior driving evaluation group.
- ☐ I would like to reduce the need to drive by considering options such as home delivery.

If I start having problems remembering my pills or doing my daily tasks, here are some possibilities to help: *(please check)*

- ☐ Write notes and label items that get used regularly.
- ☐ Get organized so I perform the same routine every day.
- ☐ Have a pharmacy pre-pack my pills
- ☐ Think about having someone come in once a week or more as needed to help with filing pill boxes and ensuring that medications are taken.

Consider getting a medical alert or ID bracelet with your name and an emergency phone number on it. Do NOT put your own phone number on it. It might be best to put a number of someone local who could pick you up if needed. *(please check)*

- ☐ If it would help me, I would like to get a medic alert bracelet in the future.

My goal is to: *(please check)*

- ☐ I am open to having someone help me in my home if it means I can stay there longer.
- ☐ I would like to move in with: _____
- ☐ My goal is to remain in my home as long as it is safely possible.
- ☐ I am willing to move into a senior community.

I would like to talk about my future health care plans with:

Name of Person _____

Contact Information _____

My after-life plan is to be *(please check)*

- ☐ Buried
- ☐ Cremated
- ☐ Other: _____

If I am to be buried, I have made arrangements with

Name of Cemetery/Burial place _____

Contact Information _____

I have made funeral arrangements with

Name of Person _____

Contact Information _____

This person knows my after-life plans

Name of Person _____

Contact Information _____

Religious Information

My Religious Institution _____

Contact Information _____

Do you want them Contacted? Yes ____ No ____

Last Rites? Yes ____ No ____

Additional notes somebody should know:

_____

_____

_____

_____

_____

_____

_____