Palliative Care

What should go in a patient's personal health record?

One of the most important things you can do as a patient (or caregiver) is keep track of illness by recording appointments, health wishes, health records and medications. This information is often referred to as a personal health record or PHR.

There are a variety of ways to create and maintain a PHR. Some people prefer paper, some electronic, and some a combination. You can keep this information in any form that works for you and your health care providers, and allows you to easily keep it up-to-date. Store the information where you can grab it quickly in an emergency, or on your way out the door to an appointment.

Information to include in a PHR

Patient medical history

- Diagnosis
- Physician contact information
- Allergies
- Health history (e.g. surgeries, medical conditions)
- Laboratory results, pathology reports, hospital/ other discharge summaries, radiology results, etc.

SentaraMyChart patients can access this information through their electronic medical chart and share it with their care team.

Medication list

- Prescription medications
- Discontinued medications (along with reason they were stopped)
- Over-the-counter medications
- Vitamins and any supplements

Insurance information

- Private medical insurance
- Prescription plan
- Medicare/Medicaid
- Long-term care insurance
- Dental and vision insurance

Legal documents, if they've been written

- Living will
- Durable power of attorney for health care (also known as a health care proxy)
- Power of attorney for finances
- Contact information for care recipient's lawyer

For further information scan the code or visit **NavigatePalliativeCare.com**

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