



The Mighty's *Caregiving* Binder

Generation Care™

janssen

PHARMACEUTICAL COMPANIES OF
Johnson & Johnson

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Medication List

Medication:

Frequency/Dosage:

Prescribing Physician:

Specialty:

Additional Instructions:

Medication:

Frequency/Dosage:

Prescribing Physician:

Specialty:

Additional Instructions:

Medication:

Frequency/Dosage:

Prescribing Physician:

Specialty:

Additional Instructions:

Medication:

Frequency/Dosage:

Prescribing Physician:

Specialty:

Additional Instructions:

Pharmacy Information

Pharmacy Name:

Pharmacy Phone Number:

Please consult your doctor or other qualified healthcare provider with any questions you may have regarding a medication or treatment.

Medical Team



Physician Name:

Specialty:

Phone Number:

Last Seen:

Upcoming Appointment(s):

Physician Name:

Specialty:

Phone Number:

Last Seen:

Upcoming Appointment(s):

Physician Name:

Specialty:

Phone Number:

Last Seen:

Upcoming Appointment(s):

Physician Name:

Specialty:

Phone Number:

Last Seen:

Upcoming Appointment(s):



Allergy List

Allergen:

Reaction:

Treatment:

Allergen:

Reaction:

Treatment:

Allergen:

Reaction:

Treatment:

Allergen:

Reaction:

Treatment:

Allergen:

Reaction:

Treatment:

Allergen:

Reaction:

Treatment:

Procedure History

Date:

Physician Name:

Procedure Type:

Location:

CIRCLE ONE

Outpatient/Hospitalized: _____ Day(s)

Date:

Physician Name:

Procedure Type:

Location:

CIRCLE ONE

Outpatient/Hospitalized: _____ Day(s)

Date:

Physician Name:

Procedure Type:

Location:

CIRCLE ONE

Outpatient/Hospitalized: _____ Day(s)

Date:

Physician Name:

Procedure Type:

Location:

CIRCLE ONE

Outpatient/Hospitalized: _____ Day(s)





In Case of a *Crisis*

Patient Name: _____

Patient Birth Date: _____
(MM/DD/YYYY)

Patient Address: _____
STREET

CITY STATE ZIP CODE

Next of Kin: _____
NAME

RELATIONSHIP PHONE NUMBER

Nearest Hospital: _____

Preferred Hospital: _____

Family Doctor: _____
NAME

PHONE NUMBER

Insurance Information: _____

Primary Caregiver: _____
NAME

PHONE NUMBER

CAREGIVER'S LOCATION



Patient Blood Type:

NOTES: _____

Additional Documents

This is a list of additional forms and legal documents you could include in this caregiving binder.

- Do-Not-Resuscitate (DNR) Order** - A medical order written by a doctor. It is only valid if it has been signed by the patient. It instructs health care providers not to do CPR if a patient stops breathing or if their heart stops.
- Emergency Contact List** - An additional list of people to call and notify if there's an emergency.
- Health Care Surrogate/Proxy** - A legal, signed document that authorizes a person to make medical decisions (e.g., psychiatric treatment, nursing care, hospitalization, home health care, etc.) for when the patient is unable to do so on their own.
- HIPAA Authorization Form** - This form authorizes health care professionals to only share the patient's medical status/records with appointed loved ones.
- Living Will/Advance Directive** - A written statement that details a person's desires regarding their medical treatment, including pain management and organ donation.
- Power of Attorney (POA)** - A legal document giving one person the power to act for another person. Depending on the terms, this person has legal authority to make decisions about the patient's property, finances or medical care.

