

**This Healthcare Management Binder  
is sponsored by**

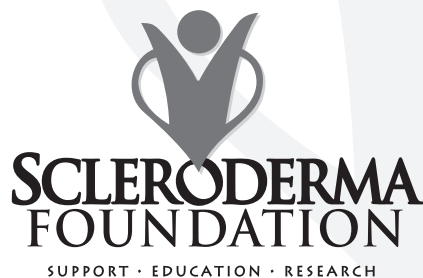


*Actelion Pharmaceuticals US  
is proud to be the  
2011 National Gold Sponsor of the Scleroderma Foundation*

## Our Three-Fold Mission of Support, Education, and Research

- **Support:** To help patients and their families cope with scleroderma through mutual support programs, peer counseling, physician referrals, and educational information.
- **Education:** To promote public awareness and education through patient and health professional seminars, literature, and publicity campaigns.
- **Research:** To stimulate and support research to improve treatment and ultimately find the cause of and cure for scleroderma and related diseases.

While the Foundation allocates an average of \$1 million in funds per year for research into the cause and cure of scleroderma, we also consider the other two parts of our mission very important.



*Contact Us –*

### **Scleroderma Foundation**

300 Rosewood Drive Suite 105

Danvers MA 01923

Scleroderma Foundation: 800-722-4673 (HOPE)

Fax 978-463-5809

[www.scleroderma.org](http://www.scleroderma.org)

### **Disclaimer**

Because the manifestations and severity of scleroderma vary among individuals, personalized medical management is essential. The Scleroderma Foundation has created the medical management binder as a tool and strongly recommends all treatments be discussed with the patients' physician(s) for proper evaluation and treatment recommendations.

## Personal Information

<b>Name:</b>	<b>Gender:</b> M    F
	<b>SS#:</b>
<b>Address:</b>	<b>DOB:</b>
	<b>Place of Birth:</b>
<b>Country:</b>	<b>Religion:</b>
<b>Home Phone:</b>	<b>Organ Donor:</b> Y    N
<b>Work Phone:</b>	<b>Blood Type:</b>
<b>Cell Phone:</b>	<b>Accept Blood Transfusions:</b> Y    N
<b>Primary Care Physician:</b>	<b>Phone #:</b>
<b>Emergency Contact Name:</b>	<b>Phone #:</b>
<b>Emergency Contact Address:</b>	<b>Phone 2 #:</b>
	<b>Relationship:</b>
<b>Emergency Contact Name:</b>	<b>Phone #:</b>
<b>Emergency Contact Address:</b>	<b>Phone 2 #:</b>
	<b>Relationship:</b>
<b>Medical Conditions:</b>	
<b>Allergies to Medications:</b>	
<b>Food or Environmental Allergies:</b>	

## Employment Information

<b>Employer:</b>	<b>Student:</b> Y    N
<b>Address:</b>	<b>Employer Phone:</b>
	<b>Job Description:</b>

## Insurance Information

<b>Primary Insurance Company:</b>	
<b>Address:</b>	<b>Phone #:</b>
	<b>Policy #:</b>
	<b>Group #:</b>
<b>Name of Policy Holder:</b>	<b>Relationship:</b>

<b>Secondary Insurance Company:</b>	
<b>Address:</b>	<b>Phone #:</b>
	<b>Policy #:</b>
	<b>Group #:</b>
<b>Name of Policy Holder:</b>	<b>Relationship:</b>

<b>Medicaid #:</b>
<b>Medicare #:</b>

<b>Comments</b>
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# Pulmonary Records

## Echocardiogram (Annual Screenings Recommended)

Date	Location	Result	Record Obtained

## Pulmonary Function Tests (PFTs)

Date	Location	Result















## History of Hospitalizations and Surgeries

<b>Hospital:</b>		<b>Date Admitted</b>	<b>Date of Surgery</b>	<b>Date Discharged</b>
<b>Phone:</b>	<input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient	<b>Reason for Hospitalization / Type of Surgery:</b>		
<b>Address:</b>		<b>Complications:</b>		
<b>Name of Doctor / Surgeon:</b>				

<b>Hospital:</b>		<b>Date Admitted</b>	<b>Date of Surgery</b>	<b>Date Discharged</b>
<b>Phone:</b>	<input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient	<b>Reason for Hospitalization / Type of Surgery:</b>		
<b>Address:</b>		<b>Complications:</b>		
<b>Name of Doctor / Surgeon:</b>				

<b>Hospital:</b>		<b>Date Admitted</b>	<b>Date of Surgery</b>	<b>Date Discharged</b>
<b>Phone:</b>	<input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient	<b>Reason for Hospitalization / Type of Surgery:</b>		
<b>Address:</b>		<b>Complications:</b>		
<b>Name of Doctor / Surgeon:</b>				

**Comments**

## History of Hospitalizations and Surgeries - Cont.

Hospital:		Date Admitted	Date of Surgery	Date Discharged
Phone:	<input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient	Reason for Hospitalization / Type of Surgery:		
Address:		Complications:		
Name of Doctor / Surgeon:				

Hospital:		Date Admitted	Date of Surgery	Date Discharged
Phone:	<input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient	Reason for Hospitalization / Type of Surgery:		
Address:		Complications:		
Name of Doctor / Surgeon:				

Hospital:		Date Admitted	Date of Surgery	Date Discharged
Phone:	<input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient	Reason for Hospitalization / Type of Surgery:		
Address:		Complications:		
Name of Doctor / Surgeon:				

Comments
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- Living Will** – A document where the patient can describe any life-sustaining treatment he/she may want prior to the patient being unable to make these decisions.
- Health Care Power of Attorney** – This is a legal document where the patient gives another person the power to make decisions about the patient's medical care if the patient is no longer able to communicate.
- Do Not Resuscitate form** – Intended to help people in the final stages of terminal illness or who suffer from a serious condition. They inform healthcare professionals to forgo resuscitation attempts such as, CPR, intubation, defibrillation, administration of certain drugs, etc.
- DNR (Do Not Resuscitate) Directive** – A form requested by the patient that extraordinary measures are not to be used.
- DNR Order** – a physician's order on the chart stating that extraordinary measures are not to be used in an attempt to save a patient's life.
- Birth Certificate**
- Release(s) for Medical Information**

It is highly recommended that you check with an attorney in your state to learn about required documents as these requirements may vary from state to state.

