Hospital Preferences: _____

_____

Health Insurance Info:

☐ Medicare ☐ Private ☐ Other etc.
☐ Medicaid ☐ Champus _____

_____

I Have:

☐ Swallowing Problems
☐ A Special Diet: _____

_____

☐ Other: _____

Prosthetics & Orthotics

Provider: _____
History: _____

_____

Dates of Service: _____

I need a person to help me:

☐ walk
☐ go up/down stairs
☐ carry things
☐ eat
☐ bathe
☐ push my wheelchair
☐ Other: _____

☐ go to bathroom
☐ get in/out of car
☐ get dressed
☐ express my needs
☐ prepare food
☐ with all of my care (age appropriately)

EQUIPMENT I HAVE:

Equipment	Vendor/ Phone	Last Service
Walker		
Wheelchair		
Crutches		
Splints		
Braces		
Bedside Toilet		
Shower Chair		
Tub Bench		
Hoyer Lift		
Glasses/Contacts		
Other:		

EQUIPMENT RECOMMENDED:

☐ Hand-held Shower ☐ Stroller
☐ Potty Chair/ Potty insert ☐ Other: _____

_____

CAR SEAT I USE:

☐ Infant Carrier ☐ Convertible
☐ High Back Booster & Harness ☐ Booster

SUPERVISION:

☐ When I'm awake, I need direct supervision to help me make good decisions and for increased safety.

☐ When I'm awake, I need indirect supervision. I need someone in the house with me but not in the same room. For increased safety, I need to be checked on every 30 minutes.

☐ Age appropriately, I need direct supervision for increased safety.

Other: _____

_____

_____

For more information:

Vidant Health
Rehabilitation Services
P.O. Box 6028
Greenville, NC 27835-6028

Inpatient Rehab
2100 Stantonsburg Road.....252-847-4400

Outpatient Rehab
2310 Stantonsburg Road.....252-847-6603

Rehabilitation Center at Vidant Wellness Center
2610 Stantonsburg Road.....252-847-7547

If you wish additional copies of your personal health profile, you may find them on your computer at **www.vidanthealth.com/rehab-patients/**

Note to Practitioners:
This form was provided by the Rehab Services of Vidant Health. It's designed to be updated regularly by the patient. Practitioners should confirm all entries.

VIDANT HEALTH

Pediatric Profile

Vidant Rehabilitation

Health Profile for:_____ Date:_____

Emergency contact (name & phone #): _____

1. Remember to list all medicines including vitamins, dietary and herbal supplements.
2. Cross out any medicines you do not take any more.

NAME OF MEDICINE	DATE	CURRENT DOSAGE	PRESCRIBING M.D.

HEALTH CARE PROVIDERS / PHYS.	SERVICES

ALLERGIES / SENSITIVITIES

MEDICAL CONDITION / MAJOR SURGERIES

MY PERSONAL RISK FACTORS / FAMILY HISTORY

_____

_____

_____

What comforts me: _____

_____

_____

What scares me: _____

_____

_____

IMMUNIZATIONS

VACCINE	DATE
HepB	
DTaP	
Hib	
IPV	
MMR	
HepA	
Varicella	
Tetanus	
Pneumonia Vaccine	
Seasonal Flu	
H1N1 Flu	
Other:	

Please refer to your child's State Immunization Record.