Portable Health Profile (PHP) Data Collection Form

This form contains information that is confidential. It may contain information that is privileged or exempt from disclosure under applicable law.

1. Personal Information

Name:		
Street Address:		Province:
City :	Postal Code:	
Date of Birth (MM/DD/YY):	Health Card #:	
Email:	Phone:	

2. Emergency Contacts

Name:	Name:
Relationship:	Relationship:
Street:	Street:
City:	City:
Province/Postal Code:	Province/Postal Code:
Home Phone:	Home Phone:
Mobile Phone:	Mobile Phone:

3. Medications

Medication Name	Dosage	Frequency	Provider	Phone Number

community advantage Rehabilitation

4. Known Allergies

5. Known Medical Conditions

Risk Factors

Prone to Fall ☐ Bleeding Precautions ☐ Sternal Precautions ☐ Hip Precautions ☐

Legally Blind ☐ Swelling Problems ☐ Swallowing Problems ☐ Cardiac/Repiratory Problems ☐

Other:

6. Impairment

Functional Mobility:
Vision/Hearing:
Communication:
Cognition:
Other

community advantage Rehabilitation

7. Immunizations

Name	*Date Administered*
Flu	
Pneumonia	
Tetanus	
Chicken Pox	
HPV	
COVID-19	
Other	

8. Healthcare Providers

Primary Physician:	Phone Number:
Dentist:	Phone Number:
Specialist 1:	Phone Number:
Specialist 2:	Phone Number:
Specialist 3:	Phone Number:

9. Preferred Hospital

Name:	Phone Number:

10. Health Insurance Information

Primary Insurance Plan Name:		ID Number:
Insured Name:	Phone Number:	
Group Name:	Group Number:	
Subscriber Number/ID Number:	Subscriber Name:	
Secondary Insurance Plan Name		ID Number:
Insured Name:	Phone Number:	
Group Name:	Group Number:	
Subscriber Number/ID Number:	Subscriber Name:	

11. Advance Directive

HCP ☐ DNR ☐

12. Healthcare Agent for Advance Directive

Name of Healthcare Agent:	
Location of your advanced directive?	
Phone Number:	Date updated:

12. Medical Devices

Device	*Provider*	*Contact Number*	*Date Obtained or of Last Service*