What to Take to Doctor Appointments
Always make sure that someone who knows the individual well attends the appointment!

A. Take the following documentation:
   1. List of current medications, including dosages, times administered, and prescribing physician
   2. Known drug allergies
   3. Emergency contacts (guardian, program supervisor, case manager)
   4. Health record, including at least the following:
      - Diagnosis
      - Baseline vital signs (especially if unusual)
      - Medical History including hospitalizations, surgeries, major illnesses
      - Immunization record
      - Advance directives (if applicable)
      - Special care instructions (language barriers, unusual fears, and need for sedation)
   5. Health status data (as applicable to individual’s gender & health issues)
      - Weights (current and last year’s)
      - Individual management protocols/records (i.e. asthma, diabetes, hypoglycemia, seizures)
      - Seizure frequency
      - Bowel/bladder function and/or menstrual chart
      - Fluid and nutritional intake/output
      - Sleep patterns
      - Behavioral incidence/mood

B. Be prepared to tell the physician
   1. Purpose of the appointment (check up, acute health concern, follow-up – for what?, progress)
   2. Symptoms observed
      - Temperature
      - Respiratory rate
      - When symptoms began (what happened before?)
      - What makes the symptoms worse or better
   3. Changes in the individual’s life/routine
   4. Other concerns of the patient
   5. Names of person(s) authorized to call in for test results (if relevant)