CARE NOTEBOOK

THIS NOTEBOOK IS FOR:

NEVADA DISABILITY ADVOCACY AND LAW CENTER

THE PROTECTION AND ADVOCACY SYSTEM FOR NEVADA

NEVADA DISABILITY
ADVOCACY & LAW CENTER

Table of Contents

CARE NOTEBOOK

The Care Notebook is an organizing tool for families who have children with special health care needs. The goal is to provide a central location for important information regarding your child's disability.

Record keeping is a must when parenting a child with special health care needs.

Nevada Disability Advocacy & Law Center (NDALC) has created this notebook to provide an invaluable reference tool that will make keeping your child's records easy and convenient.

The pages are available at www.ndalc.org for downloading.

This publication is for informational purposes only; it is not intended to be legal advice. If you have questions about a specific situation please contact NDALC or a private attorney.

 Materials were supported in part through funding from the State Bar of Nevada – Lawyer Referral & Information Service program

Family Information

Name: _____ Nickname: _____

Diagnosis: _____Blood Type: _____

Height:_____ Weight:_____

Daytime Phone: _____Evening Phone: _____

Address:_____

Spouse Name:

_____

Address:

_____

Daytime Phone: _____Evening Phone: _____

Legal Guardian: _____

Daytime Phone: _____Evening Phone: _____

Other household members: _____

_____

Important Family Information:

_____

_____

_____

Language(s) spoken at home: _____

Interpreter Needed? Yes: __No: __

Preferred interpreter? Name: _____Phone: _____

Emergency Contact

Name:_____Relationship_____

Address: _____

Daytime Phone: _____Evening Phone: _____

Diagnoses

Diagnosis Given	Provider who gave Diagnosis	Date Noted	Miscellaneous Notes

Allergies

Allergy	Type of Reaction	Date

SURGERIES OR PROCEDURES

Type of surgery/procedure	Surgeon/Physician/Hospital	Date(s)

HOSPITAL ADMISSIONS (FOR REASONS OTHER THAN SURGERY)

Reason for admission	Hospital	Date(s)

Seizure / Behavior Log

Seizure or Behavior	☐ **Not Applicable to me**

Only use this log if it applies to you.

Date/Time	**Duration of Seizure [or] Behavior**	**Description of Seizure** (extremities involved, intensity, etc.) **[or] Behavior you are concerned about**

Insurance, Etc.

- Insurance Name:_____
  Policy Number:_____
  Contact Person/Title:_____
  Address:_____
  _____
  Phone:_____Fax:_____

- Medicaid (HMO Name if applicable – this is the company name that appears above your name and ID Number on the Medicaid Identification Card):_____
  Policy Number:_____
  Contact Person/Title:_____
  Address:_____
  _____
  Phone:_____Fax:_____

- Insurance Name:_____
  Policy Number:_____
  Contact Person/Title:_____
  Address:_____
  Phone:_____Fax:_____Website/Email:_____

- Supplemental Security Income (SSI):_____
  Contact Person/Title:_____
  Address:_____
  Phone:_____Fax:_____Website/Email:_____

- Other:_____
  Contact Person/Title:_____
  Address:_____
  Phone:_____Fax:_____Website/Email:_____

- Other:_____
  Contact Person/Title:_____
  Address:_____
  Phone:_____Fax:_____Website/Email:_____

Health Care Providers

Primary Medical Provider _____

Address _____

City _____ State _____ Zip _____

Phone ( ) _____

Email _____

Preferred Hospital _____

Address _____

City _____ State _____ Zip _____

Phone ( ) _____

Email _____

Specialty Hospital _____

Address _____

City _____ State _____ Zip _____

Phone ( ) _____

Email _____

Specialist Name _____ Type _____

Clinic/Hospital _____

Address _____

City _____ State _____ Zip _____

Phone ( ) _____

Email _____

Specialist Name _____ Type _____

Clinic/Hospital _____

Address _____

City _____ State _____ Zip _____

Phone ( ) _____

Email _____

Specialist Name _____ Type _____
Clinic/Hospital _____
Address _____
City _____ State _____ Zip _____
Phone ( ) _____
Email _____

Specialist Name _____ Type _____
Clinic/Hospital _____
Address _____
City _____ State _____ City _____
Phone ( ) _____
Email _____

Specialist Name _____ Type _____
Clinic/Hospital _____
Address _____
City _____ State _____ City _____
Phone ( ) _____
Email _____

Dentist Name _____
Address _____
City _____ State _____ Zip _____
Phone ( ) _____
Email _____

Eye Doctor Name _____
Address _____
City _____ State _____ Zip _____
Phone ( ) _____
Email _____

Public Health Nurse _____

Address _____

City _____ **State** _____ **Zip** _____

Phone ( ) _____

Email _____

Nutritionist _____

Address _____

City _____ **State** _____ **Zip** _____

Phone ( ) _____

Email _____

Social Worker _____

Address _____

City _____ **State** _____ **Zip** _____

Phone ( ) _____

Email _____

Healthy Families Contact _____

Address _____

City _____ **State** _____ **Zip** _____

Phone ( ) _____

Email _____

Home Health Agency _____

Start Date _____ **End Date** _____

Contact Person _____

Address _____

City _____ **State** _____ **Zip** _____

Phone ( ) _____

Email _____

Home Health Agency _____

Start Date _____ **End Date** _____

Contact Person _____

Address _____

City _____ **State** _____ **Zip** _____

Phone ( ) _____

Email _____

Home Health Agency _____

Start Date _____ End Date _____

Contact Person _____

Address _____

City _____ State _____ Zip _____

Phone ( )

Email _____

Pharmacy _____

Contact Person _____

Address _____

City _____ State _____ Zip _____

Phone ( )

Email _____

Pharmacy _____

Contact Person _____

Address _____

City _____ State _____ Zip _____

Phone ( )

Email _____

Occupational Therapist (OT) _____

Start Date _____ End Date _____

Agency _____

Address _____

City _____ State _____ Zip _____

Phone ( )

Email _____

Physical Therapist (PT) _____

Start Date _____ End Date _____

Agency _____

Address _____

City _____ State _____ Zip _____

Phone ( )

Email _____

Speech-Language Pathologist _____

Start Date _____ End Date _____

Agency _____

Address _____

City _____ State _____ Zip _____

Phone ( ) _____

Email _____

Other Therapist _____

Start Date _____ End Date _____

Agency _____

Address _____

City _____ State _____ Zip _____

Phone ( ) _____

Email _____

Other Therapist _____

Start Date _____ End Date _____

Agency _____

Address _____

City _____ State _____ Zip _____

Phone ( ) _____

Email _____

Respite Care Provider _____

Start Date _____ End Date _____

Agency _____

Address _____

City _____ State _____ Zip _____

Phone ( ) _____

Email _____

Contact Log

Date	Name of Person Contacted	What was Discussed

NOTES

Nevada Disability Advocacy & Law Center

Southern Office
2820 W Charleston Blvd, Suite B - 11
Las Vegas, NV 89102
Phone: (702) 257-8150 or 1-888-349-3843
Nevada Relay: 711
Fax: (702)-257-8170
lasvegas@ndalc.org

Northern Office
1875 Plumas Street, Suite 1
Reno, NV 89509
Phone: (775) 333-7878 or 1-800-992-5715
Nevada Relay: 711
Fax: (775) 786-2520
reno@ndalc.org

Elko Office
905 Railroad Street, Suite 104B
Elko, NV 89801
Phone: (775) 777-1590 or 1-800-992-5715
Nevada Relay: 711
Fax: (775) 753-1690
elko@ndalc.org

www.ndalc.org

Nevada Disability Advocacy & Law Center (NDALC) is a private, statewide non-profit organization that serves as Nevada's federally-mandated protection and advocacy system for human, legal, and service rights for individuals with disabilities**.** NDALC was designated as Nevada's protection and advocacy system by the Governor in March, 1995.

Services provided by NDALC include, but are not limited to: information and referral services, education, training, negotiation, mediation, investigation of reported or suspected abuse/neglect, legal counsel, technical assistance, and public policy work.

NDALC has offices in Las Vegas, Reno, and Elko with services provided statewide. All services are offered at no cost to eligible individuals in accordance with NDALC's available resources and service priorities.

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