



Appendix M – Crisis Binder Printables

ADVOCACY JOURNAL

Patient Information

Patient Name: _____

Hospital/Facility: _____

Unit/Ward: _____

Primary Diagnosis: _____

POA/SDM Name: _____

Date Started: _____

Advocacy Log

Date	Time	Person/ Role	Key Information	Action Items	Follow-Up Date

Today’s Top Three Questions

- 1. _____
- 2. _____
- 3. _____

Current Priorities

- ☐ Medical Updates
- ☐ Referrals
- ☐ Testing
- ☐ Insurance
- ☐ Discharge Planning
- ☐ Family Communication
- ☐ Other: _____

FAMILY CONTACT SHEET

Primary Family Contacts

Name	Relationship	Phone	Email

Medical Team

Role	Name	Phone/Ext	Email
Most Responsible Physician			
Charge Nurse			
Staff Nurse			
Social Worker			
Physiotherapist			
Occupational Therapist			
Dietician			
Pharmacist			

Key Non-Medical Contacts

Contact	Name	Phone/Ext	Email
Insurance Advisor			
Benefits Administrator			
Human Resource			
Family Lawyer			
Accountant			
Emergency Contact			

MEDICATION & ALLERGY LIST

Patient Information

Patient Name: _____

Date Updated: _____

Medication	Dose	Frequency	Purpose

Known Allergies

Allergy	Reaction

Pharmacy Information

Pharmacy: _____

Phone: _____

Pharmacist: _____

INSURANCE SUMMARY SHEET

Insurance Information

Carrier: _____

Policy Number: _____

Group Number: _____

Member ID: _____

Advisor: _____

Advisor Phone: _____

HR Contact: _____

Coverage Overview

Prescription Drugs _____

Physiotherapy _____

Occupational Therapy _____

Mental Health _____

Home Care _____

Medical Equipment _____

Disability Benefits _____

Important Phone Numbers

Claims: _____

Customer Service: _____

Emergency Assistance: _____

HOSPITAL STAY TRACKER

Admission Information

Admission Date: _____

Hospital: _____

Unit: _____

Room Number: _____

Care Journey Tracker

Date	Tests/ Procedures	Results/ Updates	Next Step

Specialist Consultations

Specialist	Date Seen	Recommendation

DAILY ROUNDS WORKSHEET

Date: _____

Providers Present

Questions for Today's Rounds

1. What has changed since yesterday?

2. What are today's priorities?

3. What concerns you most right now?

4. What does success look like over the next 24 hours?

5. What is the expected timeline?

Notes

Action Items

Task	Owner	Due Date

DISCHARGE PLANNING WORKSHEET

Proposed Discharge Date

Medical Readiness

- ☐ Vital signs stable
- ☐ Pain controlled
- ☐ Medication plan reviewed
- ☐ Prescriptions provided
- ☐ Results reviewed
- ☐ Follow-up appointments scheduled
- ☐ Discharge summary received

Functional Readiness

- ☐ Walk safely
- ☐ Transfer safely
- ☐ Use washroom safely
- ☐ Manage medications
- ☐ Navigate home environment
- ☐ Understand discharge instructions

Home Supports

- ☐ Family support arranged
- ☐ Home care arranged
- ☐ Transportation arranged
- ☐ Food and meal plan available
- ☐ Emergency plan discussed

Equipment Required

- ☐ Walker
- ☐ Wheelchair
- ☐ Commode
- ☐ Hospital Bed
- ☐ Lift Equipment
- ☐ Other: _____

DISCHARGE PLANNING WORKSHEET (pg.2)

Follow-Up Appointments

Provider	Date	Time

Emergency Contacts After Discharge

Primary Physician: _____

Specialist: _____

Home Care: _____

Pharmacy: _____

Questions Before Leaving

- ☐ What symptoms require returning to the Emergency Department?
- ☐ Who do we call overnight if concerns arise?
- ☐ Have all new medications been reviewed?
- ☐ Is home equipment in place?
- ☐ Are follow-up appointments booked?
- ☐ Do we understand the care plan?

ADVOCATE REMINDER

Write down the plan.

Know the next step.

Know who is responsible.

You do not need to remember everything. That's what this binder is for.