15 Minute Advocate

Patient Name/DOB _____

Doctor/Specialty _____ **Date:** ____ / ____ / ____

Today's Primary Goal
(What is one thing to solve?) _____

Critical Event Log

- ☐ Recent Transition: (hospitalization, ER visits, surgeries) _____
- ☐ Environment Shifts: (changes to home layout or living situation) _____

Baseline Review (daily activities)

- ☐ Physical Chages: (falls, tremors, mobililty, appetite) _____
- ☐ Cognitive/Mood Chages: (confusion, anxiety, sleep) _____
- ☐ Medication Efficacy: (Are meds working? Any new side effects?) _____
- ☐ Communication & Swallowing: (voice volume, coughing while eating/drinking) _____
- ☐ Daily Independence: (new struggles w/dressing, bathing, eating) _____
- ☐ Functional Changes: (changes in walking or day-to-day care?) _____

Questions for the Doctor

1. _____
2. _____
3. _____
4. _____
5. Referral Request? _____

Symptom Escalation Tracker

- ☐ Motor Movement: (tremor, stiffness, slowness) Which is most bothersome? _____
- ☐ Non-Motor: (mood, confusion/memory, dizziness, constipation, bladder, pain) _____

Doctor's Orders/Next Steps

_____

_____

_____

_____