6TH Annual Sickle Cell Patient & Family Educational Symposium

CARE PLAN

Welcome to the 2019 Sickle Cell Disease Patient and Family Education Symposium! Thank you for choosing to participate in this empowering event. The symposium will be held Wednesday, July 24, 2019 through Sunday, July 28, 2019, at the Hilton Dallas/Plano Granite Park hotel and convention center. Patient (Warrior) registration is $200 per person. However, the host organizations, along with the Sickle Cell Community Consortium, have made provision by way of scholarships to reduce the cost of registration. Our goal is to ensure all Sickle Cell Warriors interested in attending the symposium are provided an opportunity.

Scholarship applicants DO NOT REGISTER FOR THE SYMPOSIUM PRIOR TO SUBMITTING A SCHOLARSHIP REQUEST. Scholarship applicants will be contacted within one (1) week to confirm his/her scholarship status. If you are interested in applying for a scholarship to reduce the cost of registration, (and lodging support if needed) please visit www.sicklecellconvention.org/scholarship for more information. Please note travel assistance is not included in this offer. Lodging support is limited and offered based upon need. Additional support is available ONLY to individuals living with Sickle Cell Disease and the caregiver/guardians of minors living with Sickle Cell Disease. All other caregivers may apply for the discounted registration registers. If awarded lodging, all rooms will be booked in doubles. Adult Warriors will be matched with a Warrior of the same gender and age range.

All Warrior scholarship recipients are asked to complete a Care Plan for Sickle Cell Disease Patients to bring with you to the symposium in case of a medical emergency. www.sicklecellconvention.org/registration.

The symposium agenda is also available at www.sicklecellconvention.org.

Scholarship recipients are required to attend the daily 10:00 am Plenary Session, in addition to attending 50% of the breakout sessions.

The Sickle Cell Community Consortium Team

CARE PLAN

Management and Care Coordination of Patients with Sickle Cell

PATIENT:	Name:	
	DOB (mm/dd/yyyy): / /	Sex: M ___ F ___
	Primary Care Provider:	
	Phone Number: ( ) -	

INSURANCE:	Carrier:	ID/Plan:
	HMO (if known):	
	Address:	
	City, State:	Zip:

MEDICAL HISTORY/ DIAGNOSIS:	

Are immunizations up to date? Yes_____ No_____

KNOWN ALLERGIES:	

MEDICATION (S):			
NAME	**DOSAGE**	**FREQUENCY/DAY**	**LAST TAKEN**

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MEDICATION (S): (continued)			
NAME	DOSAGE	FREQUENCY/DAY	LAST TAKEN

SICKLE CELL SICK PLAN:	

PHARMACY:	Pharmacy Name:	
	Phone: ( ) -	Fax: ( ) -

EMERGENCY CONTACT:	FIRST CONTACT	SECOND CONTACT
	Name:	Name:
	Phone:	Phone:

Medical Release, provider and patient signatures:

____ _______________

Physician/Healthcare Provider Date

____ _______________

Patient Date

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