myHAEcheckup.ca CARE PLAN

Name: _____ **Date of Birth:** _____

Tel: _____ **Healthcard No.:** _____

Complete this form with your healthcare provider.

EMERGENCY CONTACT:

Name: _____ Relationship: _____

Primary Tel: _____ Secondary Tel: _____

PHYSICIAN DETAILS:

Name: _____ Tel: _____

Email: _____ Fax: _____

TYPICAL CLINICAL MANIFESTATIONS OF HAE ATTACKS:

- ☐ Laryngeal/airway swelling
- ☐ Facial/neck swelling
- ☐ Abdominal pain (nausea, vomiting, diarrhea)
- ☐ Peripheral swelling (lower legs, feet, arms, hands)

TREATMENT OF ACUTE ATTACKS:

If any of the above, and/or:	Do this:

Reminder: If you are having an angioedema attack involving the upper airway, you should be assessed in the emergency department.

LONG-TERM PROPHYLAXIS (LTP) TREATMENT: _____

☐ Patient has been trained on self-administration of acute and LTP treatment.

SPECIAL CONSIDERATIONS:

☐ Patient has history of laryngeal swelling requiring hospitalization/intubation.

Patient's known triggers include: _____

Additional information: _____

_____

_____

PLAN PREPARED BY:

HCP Name & Designation: _____

HCP Signature: _____ Date: _____

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