PTC Cares
STRONGER TOGETHER

Navigating Your Clinic Visits

Please leave a copy with your Healthcare Provider

Patient Name: _____ Date of Birth: _____

Today's Date: _____ Next Clinic Visit Date: _____

CURRENT MEDICATIONS

List all medications that the patient is taking for Duchenne muscular dystrophy as well as other conditions, if applicable.

- Have there been any changes to the patient's medications since you last reported them to your doctor? ◯ Yes ◯ No
  If yes, please list the changes: _____
- Are you experiencing any difficulty with access to prescribed medications? ◯ Yes ◯ No
  If yes, please describe the difficulties: _____

MEDICATION	LENGTH OF THERAPY	DOSING	PRESCRIBER NAME

PAST MEDICATIONS

List past medications that the patient has taken for Duchenne muscular dystrophy as well as other conditions, if applicable.

MEDICATION	LENGTH OF THERAPY	DOSING	PRESCRIBER NAME

OBSERVATIONS

Record changes in the patient's weight and abilities here. Share this information with your doctor regularly.

SIGN OR SYMPTOM	BASELINE DATE:	DATE:	DATE:
Weight	Baseline Weight:	Weight: Adjust Dose: ○ Yes ○ No	Weight: Adjust Dose: ○ Yes ○ No
Energy/Activity level	○ Good ○ Fair ○ Poor	○ Better ○ Worse ○ No Change	○ Better ○ Worse ○ No Change
Ability to walk	○ Better ○ Worse ○ No Change	○ Better ○ Worse ○ No Change	○ Better ○ Worse ○ No Change
Rising from floor	○ Better ○ Worse ○ No Change	○ Better ○ Worse ○ No Change	○ Better ○ Worse ○ No Change
Use of arms/hands	○ Better ○ Worse ○ No Change	○ Better ○ Worse ○ No Change	○ Better ○ Worse ○ No Change
Breathing function	○ Better ○ Worse ○ No Change	○ Better ○ Worse ○ No Change	○ Better ○ Worse ○ No Change
Mental focus	○ Better ○ Worse ○ No Change	○ Better ○ Worse ○ No Change	○ Better ○ Worse ○ No Change
Behavioral issues	○ Better ○ Worse ○ No Change	○ Better ○ Worse ○ No Change	○ Better ○ Worse ○ No Change

Record any additional observations or details, questions, or concerns you may have regarding the patient's medications or abilities here:

_____

_____

Please continue on page 2

PTC Cares
STRONGER TOGETHER

Navigating Your Clinic Visits

Please leave a copy with your Healthcare Provider

QUESTIONS to help your doctor

Have you received any vaccinations since your last visit? ◯ Yes ◯ No

Have there been any health status changes since your last visit? Please describe.

Have you received any unrelated treatment from other healthcare providers since your last visit? Please describe.

ADDITIONAL QUESTIONS

Record any additional questions you may have—and your doctor's answers here:

YOUR QUESTION	DOCTOR'S ANSWER

IMPORTANT INFORMATION

INSURANCE

INSURANCE COMPANY		NAME OF INSURED	
TELEPHONE		1ST POLICY NO.	
2ND INSURANCE COMPANY		2ND POLICY NO.	

PATIENT CARE TEAM

TEAM MEMBER	NAME	TELEPHONE

PTC THERAPEUTICS