Help is a phone call away….

Emergency Call 911

Police – Fire – Medical

Use pencil to ease making changes

Your Photo Here

KEEP INFORMATION UP TO DATE

Name: Sex: M F

Address: Date of Birth: / /

Own Guardian? (circle one) YES NO (if NO, fill in below)

Guardian Name: Home Phone #:

Address: Work Phone #:

Guardianship Status (full, limited, etc.):

EMERGENCY CONTACTS (1st responders, use these contacts)

Name: Home Phone #:

Address:

Relation: Work Phone #:

ALARM COMPANY

Phone # / Pass Code for Alarm Company:

"POINT OF SAFETY"

Identify the safe place outside your home you would go in case of a fire (e.g.; neighbors driveway, tree at end of block, mailbox, etc.)?:

COMMUNICATION ("X" all areas that apply)

( ) Verbal language:_____	( ) Non-Verbal
( ) Uses Sign Language	( ) Uses Communication Device(s)

MEDICAL DATA

Last Updated: Mo Year Blood Type:

Doctor: Phone #:

Doctor: Phone #:

Special Conditions / Remarks:

VITALS

DATE	BP	HR	RESP	BGL	TEMP

Medications	

Recent Surgeries	Date

Religion:

Living Will on file at:

Health Care Proxy on file at:

Do you have a DNR/MOLST? YES ☐ NO ☐

Where is it located?

MEDICAL CONDITIONS (check all that exist)

( ) No known medical conditions ( ) Abnormal EKG ( ) Angina
( ) Adrenal Insufficiency ( ) Asthma ( ) Bleeding Disorder
( ) Cardiac Dysrhythmia ( ) Cataracts ( ) Clotting Disorder
( ) Coronary Bypass Graft ( ) Dementia ( ) Alzheimer's
( ) Diabetes/Insulin Dependent ( ) Eye Surgery ( ) Glaucoma
( ) Heart Valve Prosthesis ( ) Hemodialysis ( ) Hemolytic Anemia
( ) Hypertension ( ) Hypoglycemia ( ) Laryngectomy ( ) Leukemia
( ) Lymphomas ( ) Malignant Hypothermia ( ) Memory Impaired
( ) Myasthenia Gravis ( ) Pacemaker ( ) Renal Failure
( ) Seizure Disorder ( ) Sickle Cell Anemia ( ) Stroke
( ) Hearing Impaired ( ) Vision Impaired ( ) Blind ( ) Deaf
( ) Other _____

ALLERGIES (medication, food, other…)	

MEDICAL INSURANCE

Med Ins Company:

Policy #:

Other Med Ins Company:

Policy #:

Medicaid #: **Medicare #:**

PERSONAL CARE ("X" the areas where you need help)

( ) Dressing and Undressing	( ) Chewing and Swallowing
( ) Bathing or Showering	( ) Mobility
( ) Grooming / Personal Care	( ) Transferring (e.g.; bed to chair, etc.)
( ) Using the Toilet	( ) Taking Medications
( ) Eating	( ) Using the Telephone