



# INFORMATION SHEET IN CASE OF EMERGENCY CALL 911

## CONTACT INFORMATION

First Name \_\_\_\_\_ Last Name \_\_\_\_\_

Address \_\_\_\_\_ Apartment Number \_\_\_\_\_

City \_\_\_\_\_ Postal Code \_\_\_\_\_

Main Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Alt. Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Health Card \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Birth Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
day month year

Primary Language(s) \_\_\_\_\_ Gender  M  F

Advanced Care Directive → On file with \_\_\_\_\_

Emergency Contact 1 \_\_\_\_\_

Main Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Alt. Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Emergency Contact 2 \_\_\_\_\_

Main Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Alt. Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Primary Care Provider \_\_\_\_\_

Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

## RELEVANT MEDICAL HISTORY

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> <b>Cardiac</b> (angina, heart attack, bypass, pacemaker) | <input type="checkbox"/> <b>Diabetic</b> (Insulin / Non Insulin Dependent) | <input type="checkbox"/> <b>Cancer</b>      |
| <input type="checkbox"/> <b>Stroke/TIA</b>  | <input type="checkbox"/> <b>COPD</b> (emphysema, bronchitis)               | <input type="checkbox"/> <b>Alzheimer</b>   |
| <input type="checkbox"/> <b>Hypertension</b> (high blood pressure)                | <input type="checkbox"/> <b>Seizure</b> (convulsions)                      | <input type="checkbox"/> <b>Dementia</b>    |
| <input type="checkbox"/> <b>Congestive heart failure</b>                          | <input type="checkbox"/> <b>Asthma</b>                                     | <input type="checkbox"/> <b>Psychiatric</b> |

Other \_\_\_\_\_

## MEDICATIONS

1) _____	6) _____	11) _____
2) _____	7) _____	12) _____
3) _____	8) _____	13) _____
4) _____	9) _____	14) _____
5) _____	10) _____	15) _____

## MEDICAL ALLERGIES

No Known Allergies   
  Penicillin   
  ASA (Aspirin)   
  Sulpha   
  Codeine

Other \_\_\_\_\_

## SPECIAL CONSIDERATIONS

Communicable Infection / Disease \_\_\_\_\_

Other \_\_\_\_\_

Hospital affiliation \_\_\_\_\_ →  Extensive history,

Specialty (Dialysis, neuro, etc.) \_\_\_\_\_

## MOBILITY / SENSORY

Dentures                   
  Visual (impairment / glasses / blind)                   
  Hearing (impairment / aid / deaf)

Mobility issues (cane / wheelchair / walker / motorized scooter / prosthetic limb)

## PET CARE CONTACTS

Contact 1 \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Contact 2 \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

List of pets and pet care instructions \_\_\_\_\_

\_\_\_\_\_

Completed by \_\_\_\_\_ Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
day                                  month                                  year