RESIDENT EMERGENCY INFORMATION

Name of Facility: _____ Date Form Completed: _____

Street Address: _____ Name of Caregiver: _____

Phone Number: _____ Mailing Address: _____

GENERAL RESIDENT INFORMATION

Name of Resident: _____ DOB: _____ Martial Status: ____ Sex: ____

Next of Kin (or Emergency Contact / Relationship)

_____ Phone: _____

Next of Kin (or Emergency Contact / Relationship)

_____ Phone: _____

Legal Guardian/Power of Attorney

_____ Phone: _____

Medical Plan / Insurance # _____

Primary Physician: _____ Phone: _____

Physician: _____ - _____ Phone: _____
Specialty Name

Physician: _____ - _____ Phone: _____
Specialty Name

Physician: _____ - _____ Phone: _____
Specialty Name

Physician: _____ - _____ Phone: _____
Specialty Name

Physician: _____ - _____ Phone: _____
Specialty Name

Dentist: _____ Phone: _____

MOBILITY

____ Fully Ambulatory (Does not need assistance) ____ Needs Assistance

____ Wheelchair ____ Bed Bound

____ Uses Assistive Device: (Specify walker, 3-prong cane, etc.) _____

COMMUNICATION NEEDS

Primary Language: _____

Communication Needs: _____ Communication Devices Used: _____

SPECIAL NEEDS

_____ Deaf _____ Blind

_____ Developmental Disability (Describe) _____ Other Special Needs _____

RESIDENT EMERGENCY INFORMATION

Resident: _____

MEDICAL INFORMATION

Diagnosis: _____

_____

_____

_____

Pertinent Medical History: _____

_____

_____

_____

Advance Directive? Yes ___ No ___

Date of Last TB Test: _____ TB Test Result: _____

Diet: _____ Allergies: (Medications, Food, Environmental)

Medical Equipment: _____ _____

MEDICATIONS

May attach MAR / Flow Sheet

Name of Medication	Dosage	Frequency	Route