

In Case of An Emergency

Date Form Completed: _____ Current Age: _____

INFORMATION IS FOR:

Last Name: _____

First Name: _____

Middle Initial: _____

Social Security Number: _____ - _____ - _____

Blood Type: _____

Medications Allergic To: (See Below)

EMERGENCY PHONE NUMBERS (besides 911):

Fire: _____

Police: _____

Ambulance: _____

Hospital: _____

DIRECTIONS - To provide Emergency Personnel *directions to your home*:

Subdivision or Condo Association: _____

Nearest Intersections: _____

Nearest Major Roads: _____

OTHER PERSONAL INFORMATION

Date of Birth: _____

House Number _____

Street: _____

City _____

State _____ Zip _____

Home Phone # (____) _____ - _____

Driver's License # _____

Height: _____ Weight: _____

Hair Color: _____ Eyes: _____

Pacemaker: () yes () no

Eye Glasses: () yes () no

Contact Lens: () yes () no

False Teeth: () yes () no

Birthmarks or Scars/Where: _____

PHYSICIAN(s):

Primary Care Doctor _____

City/State: _____

Telephone Number _____

Emergency Service _____

Specialist (identify)

City/State: _____

Telephone Number _____

Emergency Service _____

HOSPITAL(s) -

Name the *preferred hospital* or one covered by your insurance

If necessary transport me to the following hospital:

INSURANCE:**Primary**

Carrier (i.e. Prudential etc) _____

Policy # _____ Group # _____

Policy Holder's Name: _____

Phone: _____

Pre-Certification Phone: _____

Secondary (Medicaid, Medicare, etc.)

Carrier _____

Policy # _____ Group # _____

Policy Holder's Name: _____

Phone: _____

Pre-Certification Phone: _____

EMERGENCY CONTACT(s)

Name _____

Relationship to you _____

Phone Number _____

Cell Phone/Pager _____

Name _____

Relationship to you _____

Phone Number _____

Cell Phone/Pager _____

OTHER PERTINENT DOCUMENTS/INFORMATION

If applicable, attach document to this sheet

Living Will ☐ yes ☐ noDo Not Resituate ☐ yes ☐ noOrgan Donor: ☐ yes ☐ no**Medical Power of Attorney:**

Person Designated: _____

Telephone Number _____

Cell Phone/Pager # _____

CHRONIC MEDICAL CONDITION(s)

(Identify, i.e. Huntington's Disease, Cancer, Congestive Heart Failure, Diabetic I or II, Emphysema, Epilepsy, Seizures, Kidney or Liver disease etc.)

Condition: _____

Diagnosed: _____

Specialist: _____

Condition: _____

Diagnosed: _____

Specialist: _____

OTHER MEDICAL CONDITIONS:

(Identify i.e. Hearing Loss, Blind, Anemia, Thyroid Disease, High Blood Pressure, etc.)

Condition: _____

Diagnosed: _____

Specialist: _____

Condition: _____

Diagnosed: _____

Specialist: _____

VACCINATIONS - Year of last vaccination

___ Tetanus/diphtheria

___ Pneumococcal vaccine

___ Flu vaccine

___ Measles, mumps, rubella

___ Polio

___ Varicella (chickenpox)

___ Hepatitis A

___ Hepatitis B

ALLERGIC TO - DO *NOT* GIVE:

(list everything i.e. Morphine causes rash, etc.)

Allergic to: _____

Reaction: _____

Allergic to: _____

Reaction: _____

Allergic to: _____

Reaction: _____

SPECIAL INSTRUCTIONS:

Identify i.e.: Keep Calm/Tends To Hyperventilate When Excited-Seizure Prone;

Do Not Use Restraints; Keep Head Elevated/Swallowing Difficulties, etc.

CURRENT PRESCRIPTION MEDICATION(s)

List or use the [Medication Form](#) and say "See Attached"

HOSPITALIZATIONS & SURGERIES

Name:

Date of Birth:

Reason for Hospitalization:	Date

Reason for Surgery:	Date

Allergies:

FAMILY HISTORY

Courtesy of Jean Miller

Family History

(consider neurological disease, heart disease, diabetes, cancer, migraines, etc.)

Father Living () Yes () No Age at death ____

Medical conditions and/or cause of death _____

Mother Living () Yes () No Age at death ____

Medical conditions and/or cause of death _____

Spouse Living () Yes () No Age at death ____

Medical conditions and/or cause of death _____

Brother(s) Living () Yes () No Age at death ____

Medical conditions and/or cause of death _____

Sister(s) Living () Yes () No Age at death ____

Medical conditions and/or cause of death _____

Paternal-Grandfather Living () Yes () No Age at death ____

Medical conditions and/or cause of death _____

Paternal-Grandmother Living () Yes () No Age at death ____

Medical conditions and/or cause of death _____

Maternal-Grandfather Living () Yes () No Age at death ____

Medical conditions and/or cause of death _____

Maternal-Grandmother Living () Yes () No Age at death ____

Medical conditions and/or cause of death _____

Identify any Uncles and Aunts with medical conditions/identify condition:

UMDF Note: Gaining an understanding of family history can be an important part of understanding any disease with possible genetic influence.

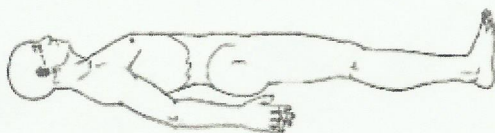
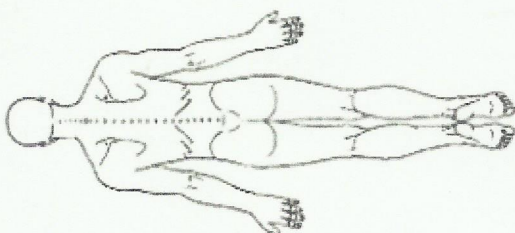
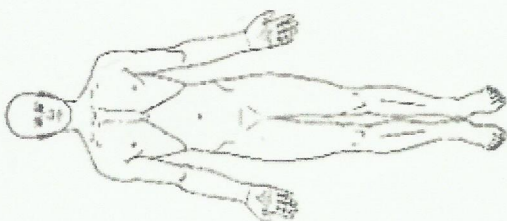
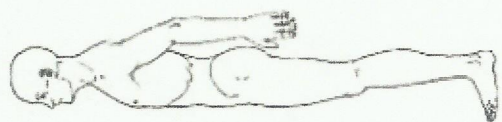
You can search your family tree at www.familysearch.org. In addition, you can download their Personal Ancestral File database for free and set up your own family tree.

Vital Signs Flow Sheet

[illegible]

Wound or Injury Care Tracker Chart

[illegible]



What I'm Taking	Reason for Use	Form <small>(pill, patch, liquid, injection, etc.)</small>	Dosage	How Much & When	Use <small>(regularly or occasionally)</small>	Start/Stop Dates <small>(1/05/05 – 3/05/05) (1/01/94 – ongoing)</small>	Notes or Special Directions
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*Be sure to include ALL prescription drugs, over-the-counter drugs, vitamins, and herbal supplements.

1							
2							
3							
4							
5							
6							
7							
8							
9							
10							

DAILY MEDICATION ADMINISTRATION LOG

Name: _____

Medication:

[illegible]

MEDICATION & SUPPLEMENT LOG

Name: _____

[illegible]

SIDE EFFECTS

Name: _____

Medication: _____

Side Effect	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Nausea and/or Vomiting							
Drowsiness							
Fatigue							
Sore/Dry Mouth							
Itching/ Rash							
Constipation Or Diarrhea							
Other							

DAILY HYGIENE SCHEDULE

Sticking to a routine can be very important! Identify each activity that your loved one is accustomed to and any special thing the caretaker must consider. I.e. like using an electric toothbrush, frequency of brushing teeth, assistance with rinsing mouth/swallowing concerns, washing hair daily or every other day, once a week, etc.

Activity	Time(s)	Special Considerations
Bath/Shower		
Mouth care (toothpaste type)		
Hair Care (washing, brushing)		
Shaving/frequency		
Fingernails (cutting, filing etc)		
Toenails (cutting, filing etc)		
Body skin care		
Face care		
Lip care (balms, moistures)		
Hand or feet skin care		
Eye care (drops, etc.)		
Normal massage(s)		
Rotation in bed		
Other		
Bedding changed		
Mattress protection		
Pillows desired		
Covering desired		
Incontinence products		

SPECIAL CARE INSTRUCTIONS FOR

Personality Traits

General description

Describe what living with he/she is like, any unusual habits or traits requiring special attention.

Basic Characteristics & Personality

Provide overall description of personality and describe any unique characteristics, which would help the caretaker understand any special needs

Abilities & Skills

Describe what they can do alone, things they may need assistance with etc.. Things such as walking, using bathroom, eating, handling controls for TV, using phone, etc.

Able To Do Without Assistance:

Needs some assistance:

Needs full assistance:

Other (describe things they may get upset if you try to do for them):

Physical Abilities

Communication Skills

Describe any problems with communication, special signals used, storyboards or any devices used to help them communicate.

Physical Mobility

Describe in detail any special requirements where assistance may be needed like getting up from a sitting/laying position, wheelchair, toilet, walking, etc. and how the person feels most comfortable getting assistance (i.e. hold from behind; lift from front until stable on feet, etc.)

Hearing Ability

Do they wear a hearing aid? Does volume of TV/radio need to be at a special level? Is there any sensitivity to loud noises? What, if anything, should be avoided?

Seeing Ability

Do they wear glasses, if so what are they needed for? (Reading, TV, walking, etc.)

Special Considerations:

Do they have a movement disorder where special consideration is needed? Are things such as special utensils or wrist weights, etc. utilized?

CLOTHING

Favorite type of clothing

Are there any clothes they prefer? Any to be avoided?

Favorite Colors and Patterns

Self-explanatory. I.e. if they like to wear pink or blue all the time, indicate.

Special Considerations

Are they hot or cold all of the time? Do they like to go barefoot? Wear shorts all the time? Prefer to wear little or no clothing? Describe any special considerations needed:

SPECIAL PLACES

Favorite Setting

Is there a favorite spot in the house they would prefer being in during different times of the day? A special chair? Are there areas that should be avoided? Why?

Mornings: _____

Afternoon: _____

Evenings: _____

Nap time: _____

Bedtime: _____

Meals: _____

Other: _____

Favorite Places/Places they like to go

Do they like to take a walk daily? Have coffee with a neighbor? Go to the movies? Indicate where the caretaker may take them in your absence.

Entertainment Preferred

Describe what they enjoy doing the most in their daily routine. Do they like having a book or newspaper read to them? Listen to a favorite tape, radio or TV station? Are there games they enjoy playing alone or with someone?

Recreation

Are there daily or weekly schedules of outings? Do they enjoy being taken to a nearby park? Will someone be taking them to a movie, etc..

Habits & Hygiene

Personal Habits

Describe any personal traits the caretaker should be aware of: for example if the person hates bathing, changing clothes, changes clothes frequently, or has any compulsive tendencies

Grooming (see Daily Schedules below)

Indicate how much assistance is required and normal daily schedule for each.

Dental Care _____

Bathing _____

Shaving _____

Hair Care _____

Toileting _____

Personal Care _____

Dressing _____

Other/Additional Details: _____

Cleanliness and Neatness

Indicate personal habits, areas of difficulty, special needs for protective clothing etc.

Bathroom

Describe any special needs that should be considered. What is their level of urgency, i.e. should they be taken immediately to a restroom when they indicate they need to relieve themselves? Are they incontinent? If yes, what special things need to be considered?

Bathing

Do they need assistance? Prefer shower or tub? Any special equipment, like a tub chair required? Do they have any preference for soaps or shampoos? Do they like to linger or get it over with quickly? What is their level of modesty, what might embarrass them?

PERSONAL PREFERENCES

Foods

List any favorite foods

Eating Habits

Describe things like whether snacks are allowed, how often, types? Any precautions to be taken with monitoring them while eating, special utensils, etc.

Special Food Considerations

Describe foods to be avoided for swallowing considerations, gas, etc., whether meals should be prepared in a certain way (cut into small pieces, pureed, soft-foods, thickeners added, etc.)

Drinks

Describe liquids to be avoided, whether thickeners need to be added, favorite drinks, etc. If there are special recipes or prepared drinks identify them.

Sleeping Habits

What are their normal sleeping schedules? Should they be kept awake certain hours? What clothing do they prefer to sleep in? Do they prefer sleeping on their side or back? Is it okay for them to sleep on couch or other area?

Hobbies & Interests

Describe/let caretaker knows if there are items around the house reflecting the person's hobby/interest that could be brought out and talked about. Do they participate in a hobby on a regular basis, etc?

Social Support

Are there special people in their life who they may want to talk with or have visit? Who is allowed to visit in your absence? Who is not?

Name _____ Phone _____

Address _____

City _____ State _____ Zip _____

Who they are: _____

They are: ☐ Allowed To Visit Anytime ☐ Must Call First ☐ Must Wait Until You Return

Name _____ Phone _____

Address _____

City _____ State _____ Zip _____

Who they are: _____

They are: ☐ Allowed To Visit Anytime ☐ Must Call First ☐ Must Wait Until You Return

Name _____ Phone _____

Address _____

City _____ State _____ Zip _____

Who they are: _____

They are: ☐ Allowed To Visit Anytime ☐ Must Call First ☐ Must Wait Until You Return Updated to Web Jan 2012