WASHINGTON COUNTY

EMERGENCY INFORMATION FORM

Community Care Transitions Team

FIRST NAME	INITIAL	LAST NAME	DOB

STREET	CITY	STATE	ZIP CODE	TELEPHONE

TRANSFERRING DEVICES

HEARING AID Y/N

VISION IMPAIRED Y/N

SPEECH IMPAIRED Y/N

DENTURES upper / lower

OTHER DEVICES: (cane, wheelchair, walker …)

_____

LANGUAGE

PREFERRED LANGUAGE _____

PHYSIQUE

DATE _____

HEIGHT _____

WEIGHT _____

CURRENT MEDICAL CONDITIONS

DOCTORS, HOME HEALTH CARE/ HOSPICE PROVIDERS and NUMBER

SPECIAL INSTRUCTIONS

Advanced Directive Y/N

Funeral Arrangements Y/N If yes, list name and number _____

HEALTH INSURANCE POLICY and POLICY NUMBER

EMERGENCY CONTACT - Name, Address, Number, Relationship

PLACE ON REFRIGERATOR OR TAPE INSIDE CUPBOARD

CONT'D ON BACK

MEDICATIONS

DATE: _____

MEDICATION	DOSE	ROUTE	FREQUENCY	PRESCRIBED BY

KNOWN ALLERGIES **(including food and/or medications) :**