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 ___ ___ ___ ___ - ___ ___ ___ - ___ ___ ___ - ___ ___ (version code) 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

☐ **Cardiac** *(angina, heart attack, bypass, pacemaker)*	☐ **Asthma**	☐ **Cancer**
☐ **Stroke/TIA**	☐ **COPD** (emphysema, bronchitis)	☐ **Alzheimer**
☐ **Hypertension** (high blood pressure)	☐ **Seizure** (convulsions)	☐ **Dementia**
☐ **Congestive heart failure**	☐ **Diabetic** *Insulin / Non Insulin Dependant*	☐ **Psychiatric**

Other: _____

MEDICATIONS

1) _____ 6) _____ 11) _____

2) _____ 7) _____ 12) _____

3) _____ 8) _____ 13) _____

4) _____ 9) _____ 14) _____

5) _____ 10) _____ 15) _____

MEDICAL ALLERGIES

☐ No Known Allergies ☐ Penicillin ☐ ASA ☐ 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)

Completed by _____ Date ___ ___ / ___ ___ / ___ ___ ___ ___
day month year