

ADD NAME

ADD Address, Home Phone, Cell Phone, Email

DOB ?? /?? /??

SS# ???-??-??

ALLERGY: ADD or NOTE NONE

- ADD NOTES ABOUT PERSON: COMMUNICATION, LEARNING PREFERENCE, SPECIAL NOTES

PRIMARY DIAGNOSIS

AGE: **ADD**

HEIGHT **ADD (ADD inches)**

WEIGHT **ADD**

List Overall Diagnosis First- Then Prioritize Issues By Systems. Include Dates of Surgeries, And ICD-9 Codes

ARRANGE LISTING IN ORDER OF PRIORITY /LIFE THREATENING

1. **NEURO/MUSCULAR**
2. **RESPIRATORY**
3. **GASTRO**
4. **ORTHOPEDIC**
5. **UROLOGICAL**
6. **BLOOD TYPE**
7. **SPECIAL NOTES**

Ports? Inplants?

MEDICAL

List primary and specialists
- Include ph and beeper

HOSPITAL

LIST Hospital, City, State - and recent admission dates

IMMUNIZATIONS

Flu **ADD DATE** Pneumo **ADD DATES** Tetanus **ADD DATES**
DPT **ADD DATES** Measles **ADD DATE** Mumps **ADD DATE**
TB **ADD DATES**

Are there other issues to note like? **ENTERAL feeding? Include rate and product.**

MEDICATIONS

Rx DAILY

- | | | |
|---------------------|-----------|--------|
| 1. ADD NAME OF DRUG | DOSE/FREQ | REASON |
| 2. ADD NAME OF DRUG | DOSE/FREQ | REASON |
| 3. ADD NAME OF DRUG | DOSE/FREQ | REASON |
| 4. ADD NAME OF DRUG | DOSE/FREQ | REASON |

Rx MONTHLY

- | | | |
|---------------------|-----------|--------|
| 1. ADD NAME OF DRUG | DOSE/FREQ | REASON |
| 2. ADD NAME OF DRUG | DOSE/FREQ | REASON |

Rx PRN

- | | | |
|---------------------|-----------|--------|
| 1. ADD NAME OF DRUG | DOSE/FREQ | REASON |
| 2. ADD NAME OF DRUG | DOSE/FREQ | REASON |

HERBS / DROPS

List ALL herbs

Area for Special Notes Such as

Vent settings
Diabetic routines

List ANYTHING that would help EMS know what your health issues are.

List items/issues you want to know to be able to share with others.

List dates of major surgeries or hospital admissions and reason.

INSURANCE

ADD NAME OF INSURANCE COMPANY
ADD NAME OF SUBSCRIBER/RELATIONSHIP
Primary Subscriber: ADD SUBSCRIBER #
ADD Plan Code
Customer service: ADD #
ADD PLAN #

ADD NAME OF INSURANCE COMPANY
ADD NAME OF SUBSCRIBER /RELATIONSHIP
Secondary Subscriber: ADD SUBSCRIBER #
ADD Plan Code
Customer service: ADD #
ADD PLAN #

HEALTH SURROGATE

ADD NAME (RELATIONSHIP) PHONE #s- CELL, WORK, HOME

INSURANCE Case Manager
Health Vendor
Home Nursing Agency
Pharmacy

ADD NAME
ADD NAME
ADD NAME
ADD NAME

ADD PHONE #
ADD PHONE #
ADD PHONE #
ADD PHONE #

ext. ADD

ADD PHONE #

acc't. # ADD

acc't. # ADD