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 ___ ___ ___ ___ - ___ ___ ___ - ___ ___ ___ - ___ ___ **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)
☐ **Diabetic** (Insulin / Non Insulin Dependant)
☐ **Cancer**
☐ **Stroke/TIA**
☐ **COPD** (emphysema, bronchitis)
☐ **Alzheimer**
☐ **Hypertension** (high blood pressure)
☐ **Seizure** (convulsions)
☐ **Dementia**
☐ **Congestive heart failure**
☐ **Asthma**
☐ **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** (Aspirin) ☐ **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