



INFORMATION SHEET

IN CASE OF EMERGENCY

CALL 911



CONTACT INFORMATION

First Name \_\_\_\_\_ Last Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ Zip Code \_\_\_\_\_

Main Phone ( ) - Alt. Phone ( ) -

Gender [ ] Male [ ] Female Birth Date / / MONTH DAY YEAR

Primary Language(s) \_\_\_\_\_

[ ] Advanced Care Directive -> On File With \_\_\_\_\_

[ ] Do Not Resuscitate -> Attach copy or give location where kept \_\_\_\_\_

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 Dependent) Psychiatric

Other: \_\_\_\_\_

Please fold in half so that "In Case of Emergency" page header shows and post on Refrigerator! Re-designed from the Toronto EMS ICE Sheet

## MEDICATIONS

- 1) \_\_\_\_\_ 2) \_\_\_\_\_ 3) \_\_\_\_\_  
4) \_\_\_\_\_ 5) \_\_\_\_\_ 6) \_\_\_\_\_  
7) \_\_\_\_\_ 8) \_\_\_\_\_ 9) \_\_\_\_\_  
10) \_\_\_\_\_ 11) \_\_\_\_\_ 12) \_\_\_\_\_  
13) \_\_\_\_\_ 14) \_\_\_\_\_ 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 \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
MONTH DAY YEAR