HealthACR LLC

EMERGENCY MEDICAL INFORMATION FOR:

Name: _____

As of (date)**:** _____

Key Information

Name of patient	
Nickname (if any)	
Address- street #	
Address – Apt #	
Address – city	
Address – State & zip	
Cell phone – If yes, bring along with charger	
Date of birth	
Allergies	
Does patient wear glasses or contacts? If yes bring along with solution and case	
Does patient wear hearing aids? If yes bring them with charger	
Emergency Contact #1 (name, relationship & phone)	
Emergency contact #2 (name, relationship & phone)	

HealthACR LLC

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Name: _____

As of (date)**:** _____

What key things you should know about patient	

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MEDICATION LIST (if "as needed" indicate "as needed or PRN)

Name of Medication	**What it is for**	**Form (tablet, liquid, injection)**	**Dosage**	**Frequency/time of day** (PRN = As Needed)	**Prescribed by?** (OTC = Over the Counter)

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Medical History (medical conditions, past surgeries & hospitalizations)

1. Which hospitals/health care systems have most current electronic medical records? (current electronic record sharing will allow fast access if needed)

2. Please list medical/mental health/substance abuse conditions/history:

3. Please list surgeries (inpatient and outpatient) and approximate dates:

4. Please list hospitalizations, reason, duration and approximate dates:

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List of Providers & Contact Information

Name of provider	Type of provider	Reason you see this person	phone	Address of office you go to

EMERGENCY MEDICAL INFORMATION FOR:

Name: _____

As of (date)**:** _____

HIPAA Release FORM – see attached

Copy of Insurance Cards – see attached

Healthcare Proxy/POA see attached

Advanced Directives – See attached

MOLST or POLST (per State requirement) see attached