

FORM # 750 (A) Emergency Medical Information

Clark Quality Care

Individual: _____ DOB: _____ Medicaid #: _____
Police / Fire / Rescue 911 Poison Control Center 1-800-552-6337

WHOM TO CONTACT IN AN EMERGENCY:

Name:	Relationship:	Address:	Phone:
1			
2			

ADVANCE DIRECTIVE yes no **If yes, please provide staff a copy.**

Able to communicate verbally in an emergency? yes no **If no, how is communication made? (in writing, by communication board, etc.)**

Any History of Substance Abuse? yes no **Explain:**

Current significant medical problems (including asthma, cancer history, cardiac history, hypertension, stroke, seizure, diabetes, sexually transmitted diseases, TB, HIV, hepatitis, other communicable diseases, sensory, ambulatory):

Other information (e.g., walks with a cane, uses wheelchair, other medical needs, communication problems, sensory problems, conditions affecting transportation services, etc.):

ALLERGIES

Food:	Drugs:	Stings/Bites:
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Dietary Restrictions:

CURRENT MEDICATIONS
 (prescribed or over the counter)
 See also any meds listed on Physician Order Sheet.

	DOSE	TIME(S)	REASON / OTHER INSTRUCTIONS OR START DATE
1.			
2.			
3.			
4.			
5.			
6.			
7.			

MEDICAL PROVIDER NAME & SPECIALITY ADDRESS PHONE/FAX

1.		
2.	Dentist:	
3.		
4.		
5.		
6.		

PHARMACY:

HEALTH INSURANCE COMPANY: **POLICY #:** **GROUP #:**

Signature of person providing the above information: **Relationship to Individual:** **Date:**

Employee Signature: (Original on file in the individual's' chart) **Date received & reviewed:**

OFFICE USE ONLY

STAFF: **At least annually update information above. Also, update the list of meds, above, by lining out any discontinued meds and adding new meds.**

NEXT UPDATE: **EMPLOYEE:** **NEXT UPDATE:** **EMPLOYEE:**

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