RESIDENT EMERGENCY INFORMATION

Name of Facility	Date Form Completed
Street Address	Name of Caregiver
City Zip	Mailing Address
Phone	Other Contact Number

GENERAL RESIDENT INFORMATION

Name of Resident	Birth Date	Marital Status	Sex

Next of Kin (or Emergency Contact)/Relationship	Phone Number
Next of Kin(or Emergency Contact)/Relationship	Phone Number
Legal Guardian/Power of Attorney	Phone Number
Medical Plan/Insurance #	
Primary M.D.	Phone
Other M.D.	Phone
Dentist	Phone
Case Manager	Phone

MOBILITY

Fully Ambulatory (Does not need assistance) ☐	Needs Assistance ☐
Wheelchair ☐	Bed Bound ☐
Uses Assistive Device ☐ (Specify walker, 3-prong cane, etc.)	

COMMUNICATION NEEDS

Primary Language	
Communication Needs (Describe)	Communication Devices Used

SPECIAL NEEDS

Deaf ☐	Blind ☐
Developmental Disability ☐ (Describe)	Other Special Needs

RESIDENT _____

MEDICAL INFORMATION

Diagnoses	
Pertinent Medical History	
Advance Directive? Yes ☐	**No ☐**
Date of last TB Test	**TB Test Result**
Diet	
Medical Equipment	
Allergies (Medication, Food, Environmental)	

Medications
(May attach Medication Administration Record/Flow Sheet)

Name of Medication	Dosage	Frequency	Route

Comments