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| **Name/** Nombre: | | | | | | | | | | | |
| **Profile Information/ Información:** | Gender/género: | | Height/altura: | | | | Weight/peso: | | | Hair Color/ color del cabello: | |
| Age/DOB/edad/fecha de nacimiento: | | | | | Language/Idioma: | | | | | | Religion/ Religión: |
| Home Phone/ Teléfono casa: | | | | | Cell Phone/ Teléfono celular: | | | | | | |
| Physical Address/ Dirección de su casa: | | | | | Mailing (if different)/ Dirección de envio: | | | | | | |
| City, State, Zip/ Ciudad, Estado, Zip: | | | | |  | | | | | | |
| Email Address/Correo electrónico: | | | | | | | | | | | |
| **Point of Contact** (not in the area, to contact if local phones are overloaded)/**Contacto (fuera del área)** para ayudar a un familiar en caso de emergencia: | | | | | | | | | | | |
| Name/ Nombre: | | Relationship/ Relación: | | | | | | City,State/ Ciudad, Estado, Zip: | | | |
| Main Phone/ teléfono principal: | | Secondary Phone/ Teléfono secundario: | | | | | | | | | |
| Email Address/ Correo electrónico: | | | | | | | | | | | |
| **Other Emergency Contacts/ Otro contacto de emergencia:** | | | | | | | | | | | |
| Name/ Nombre: | | | | Relationship/ Relación: | | | | | | | |
| Main Phone/ teléfono principal: | | | | Secondary Phone/Teléfono secundario: | | | | | | | |
| Email Address/ Correo electrónico: | | | | | | | | | | | |
| Care Worker Company/ Nombre de la compañía: | | | | Phone/Teléfono: | | | | | | | |
| 1 Caregiver Name/ cuidador principal: | | | | Phone/Teléfono: | | | | | | | |
| 2 Caregiver Name/ cuidador secundario: | | | | Phone/Teléfono: | | | | | | | |
| **Medical Information- Doctor/Información médica- Médico** | | | |  | | | | | | | |
| Doctor (PCP)/ Médico: | | | | Phone/Teléfono: | | | | | | | |
| Doctor (Specialist)/ Médico (especialidad): | | | | Phone/Teléfono: | | | | | | | |
| Hospital: | | | | Phone/Teléfono: | | | | | | | |
| Insurance Co./ Compañía de seguro: | | | | Phone/Teléfono: | | | | | Policy Number/# de póliza: | | |
| **POLST or Advanced Directive (goes with the person/patient, attach copy)** Check?  Órdenes médicas sobre el tratamiento para mantener la vida (POLST) o Voluntades anticipadas (acompaña a la persona/paciente) ¿hecho? | | | | | | | | | | | |
| **Include a Current Medication List (See other side)** /Medicamentos que toma actualmente (lista en el reverso) Condiciones actuales o crónicas | | | | | | | | | | | |
| **Pets** (Attach a photo to help locate them if lost) **Mascotas** (Foto adjunta, Para identificarlos) **Pet’s Name/Mascotas Nombre**: | | | | | | | | | | | |
| Kind/ Mascotas-Tipo: | | | | | | Breed/Markings/ Raza o marcas: | | | | | |
| Vet or Pet Sitter Phone/ o Cuidador | | | | | | Where would your pet go/hide in an emergency/¿Dónde podrían encontrarse en una emergencia? | | | | | |

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| **Patient Name:** | | | | |
| Pharmacy: | | | Phone: | |
| Blood Type: | Allergies: | | | |
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| **Devices/Equipment**: Glasses, Hearing Aid, Walker/Cane, C-PAP Machine, Dentures/Bridge, Medical Alert | | | | |
| Current or Chronic Conditions: | | | | |
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|  | |  | **Condition** | **Prescribing Dr.** |
| Example: Aspirin | | Tab. 81mg 1x/day | Strokes and Heart Attack | Dr. Who |
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Additional Information:

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