

ADVANCE DIRECTIVES

NON-HOSPITAL DO NOT RESUSCITATE HEALTH CARE PROXY
 [] NO [] YES [] NO [] YES
 (attach original) (attach original)

IN CASE OF EMERGENCY	
NAME (First, M.I., Last)	PHONE NUMBER
ADDRESS (Street, Apt. No./City/State/Zip Code)	
TEMPORARY EMERGENCY HOUSING	
NAME / TITLE	PHONE NUMBER
ADDRESS	

PAST MEDICAL HISTORY

- | | |
|---|--|
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Breathing Problems | <input type="checkbox"/> Bleeding Problems |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Diabetic |
| <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Sight Problems |
| <input type="checkbox"/> Prosthesis: | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Hearing Aid | <input type="checkbox"/> Oxygen Dependent |
| <input type="checkbox"/> Contacts | <input type="checkbox"/> Wheelchair |
| <input type="checkbox"/> Glasses | <input type="checkbox"/> Walker |
| <input type="checkbox"/> Dentures | <input type="checkbox"/> Lifeline <input type="checkbox"/> Meals on Wheels |
| <input type="checkbox"/> Other | <input type="checkbox"/> Dialysis |

VACCINES

PNEUMOVAX DATE:	INFLUENZA DATE(S):
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OTHER/COMMENTS:

PLEASE PLACE THIS ON THE FRONT OF YOUR REFRIGERATOR



Vital Link

Information between you and your doctor



REMINDER:

Please bring this packet with you **WHENEVER** you visit your doctor, the hospital, the emergency room, a health care provider or temporary shelter and ask them to help you keep it updated.

Additional items to be taken to a temporary shelter/an evacuation: medicines, medical equipment, and supplies such as oxygen, and your pet(s).

NAME (First, M.I., Last)	Date Completed/Revised
DOCTORS' NAME	PHONE NUMBER

