Emergency Medical Fact Sheet

*Resident Name: _____

Past Medical Problems:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

New Medical Problems:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Allergies: _____

Past History:

A. Acute Hospitalizations

Diagnosis	Month/Year
1. _____	_____
2. _____	_____

B. Major Surgical Procedures before Admission

Procedure	Year
1. _____	_____
2. _____	_____

Treatments:

_____
_____
_____
_____

Treatment Status (See Progress Sheet Dated (/ /))

[ ] Durable Power of Attorney [ ] Full Code

[ ] DNR [ ] Do not Hosp. [ ] No Antibiotics

[ ] No IV's [ ] No feeding tube [ ] Comfort measures only

Responsible Party

_____

Relationship: _____

Phone: _____cell_____

Who Contacted: _____

Date/Time Contacted: _____

Initials of Individual Making Contact: _____

*Alternate Facility Sent To: _____

*Time Resident sent to Alternate Facility: ____

Initials of Individual at Alternate Facility: ____

Medications: _____
_____
_____
_____
_____

Diet/Dietary Restrictions: _____
_____
_____
_____

Functional Status:

A. Ambulation [ ] Independent [ ] Independent,Assisted Cane/Walker/Wheel chair

[ ]Confined to Bed or Chair

B. Continence

	Continent	Inc.	Intermittent
Urine	_____	_____	_____
Stool	_____	_____	_____

[ ] Indwelling Catheter – Indication _____

C. Basic ADLs	Ind.	Assisted	Dep.
Bathing	_____	_____	_____
Dressing	_____	_____	_____
Grooming	_____	_____	_____
Feeding	_____	_____	_____
Transfers	_____	_____	_____

D. Instrumental ADLs			
Cooking	_____	_____	_____
HouseKeeping	_____	_____	_____
Managing Finances	_____	_____	_____
Managing Meds.	_____	_____	_____
Walking Outdoors	_____	_____	_____
Climbing Stairs	_____	_____	_____
Get out to Community	___	_____	_____

| | | |