Easterseals Capital Region & Eastern Connecticut

Medical Services & Administration • *100 Deerfield Rd., Windsor, CT 06095* • *860-270-0600*
Vocational & Veterans Services • *22 Prestige Park Circle, East Hartford, CT 06108* • *860-728-1061*
Veterans & Adult Day Services • *24 Stott Avenue, Norwich, CT 06360* • *860-859-4148*

Emergency Contact/Medical Information

Name: DOB: Date:

Name of Parent, Guardian, Conservator *(if applicable)* : _____

Name of Employer of Patient or Parent(s): _____ Employer Phone Number: _____

Address of Employer: _____

Emergency Contact Name: _____ Primary Phone Number: _____

Emergency Contact Address: _____ Alternate Phone Number: _____

_____

Additional Contact Name: _____ Primary Phone Number: _____

Additional Contact Address: _____ Alternate Phone Number: _____

_____

Primary Physician Name: _____ Office Phone Number: _____

Secondary Physician Name: _____ Office Phone Number: _____

Allergies (*please include medicines, foods, insect bites, etc.*): _____

_____

Pacemaker or other implanted device? Yes No *(circle one)*

☐ **Check here if you would like a Portable Profile to take with you. Please ask receptionist for details.**

Medications *(please list all prescribed and over-the-counter medications, including those taken daily or as needed; write exactly as it appears on prescription container)* :

☐ **Check here if medication list attached or on neuropsychological intake paperwork.**

Medication	Dose/Freq	Reason For Use	Prescribing Physician

Medical History *(please list diagnoses, illnesses and surgeries)* : _____

Name: DOB: Intake Date:

Have you been hospitalized in the last five years? Yes No *(circle one)*

Reason: _____ Date: _____

Reason: _____ Date: _____

What are your expectations of services here? _____

_____

Are there any cultural tenets or religious beliefs that will impact your rehabilitation services? *(If so, please*

_____

_____

For reporting purposes:

Race/Ethnicity: ____ African American ____ American Indian or Alaska Native ____ Asian
____ Hispanic or Latino ____ Native Hawaiian or Other Pacific Islander ____ Causasian

Military Status: ____ Active Duty ____ Military/Vet Family Member Years of Service: _____
____ Veteran ____ National Guard/Reserve Branch of Service: _____
____ Non-Military Military Conflict: _____

_____

Consent to Emergency Medical Treatment and Advanced Directives

In the event of a medical emergency which necessitates medical treatment or hospitalization, Easterseals Capital Region & Eastern Connecticut may arrange for emergency medical treatment including transportation to the indicated hospital of choice. I understand and agree to the Center's policy of arranging for medical treatment in case of an emergency. I further understand that the Center does not allow staff to implement "Do Not Resuscitate" (DNR) requests or other advanced directives. Center staff will transmit a DNR request or other advanced directive to emergency medical personnel if I have provided such directive in writing:

_____ I have a "Do Not Resuscitate" (DNR) request or living will. It is my responsibility to provide a copy to the Center.

_____ I do not have a "Do Not Resuscitate" (DNR) request or living will.

Name/Address - Hospital of Choice: _____

I hereby release Easterseals Capital Region & Eastern Connecticut and its staff from any and all liability, claims, causes of action, losses, damages, costs, and expenses associated with the medical emergency treatment including transportation by ambulance. The Center may assume responsibility if the reason for medical emergency treatment resulted from an action by the Center.

I hereby authorize Easterseals Capital Region & Eastern Connecticut to disclose any protected health information necessary for medical emergency treatment.

_____ _____
Patient Signature Date

_____ _____
Parent, Guardian, or Conservator Date