Emergency Contact/Medical Information

Patient Name: ____ DOB: ________________ Date: ________________

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

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

Address of Employer: ____

Emergency Contact Name: ________________________________ Primary Phone Number: ______________________

Emergency 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 another 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)*:

Medication	Dose/Freq	Reason for Use	Prescribing Physician

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

____

____

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 the services you are seeking treatment for a result of an accident? Yes   No *(circle one)*

If yes, provide insurance and/or attorney contact information. ____

____

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

____

____

____

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