Critical Information

Last update:

Full Name: **M/F:**	**Emergency Contact:**
Current Address:	**Relationship:**
City/State/Zip:	**Phone:**
Phone:	**Email:**
Insurance Provider:	**Lives Alone Y/N:** **Still Driving Y/N:**
Provider Phone Number:	**Smokes/How Much?**
Policy/Group #:	**Drink Alcohol/How Much?**
Recent diagnoses: **Date**	**Primary Care Contact:**
	Type of physcian:
	Phone:
	Address:
	Email:
Allergies/Symptoms:	**Pharmacy Contact:**
	Phone:
	Address:
Surgeries - Type: **Date**	**Internal Devices:**
	DNR Y/N: **Living Will Y/N:**
	PEG Tube Y/N:
Recent Testing/Outcome: **Date**	**Final Directives:**
Blood Pressure _____/_____ **Glucose Level:** **Weight:**	