EMERGENCY INFORMATION VIAL
Confidential

Name: _____ **Date:** _____/_____/_____
Day Month Year

Address: _____

Date of Birth: _____/_____/_____ **Health Card #:** _____
Day Month Year

Doctor's Name: _____ **Dr. Phone #:** (_____) _____ - _____

Name of Pharmacy: _____

Emergency Contact Name: _____
Home/Cell #: _____ Business Phone #: _____
Relationship: _____ Address: _____

EXISTING MEDICAL PROBLEMS: (Check all that apply to you)

Heart:

- ○ Angina
- ○ **C**ongestive **H**eart **F**ailure
- ○ Heart Attack
- ○ Pacemaker
- ○ High Blood Pressure
- ○ Low Blood Pressure
- ○ Stroke ○ TIA's
- ○ Implanted Defibrillator

Lungs:

- ○ Asthma
- ○ Emphysema
- ○ Bronchitis
- ○ Diabetes ○ Diet ○ Meds
- ○ Cancer _____
- _____
- ○ Dialysis

Medical History:

- ○ Alzheimer's
- ○ Aneurysm
- ○ Anaemia
- ○ Epilepsy
- ○ Glaucoma
- ○ Haemophilia
- ○ Kidney
- ○ AIDS/HIV
- ○ Confusion

Allergies to Medication:

_____
_____
_____
_____

Documentation: *(Note: all documentation must be signed/witnessed originals)*

Visiting Nurses Notes: ☐ Yes ☐ No Location_____
Living Will: ☐ Yes ☐ No Location_____
Power of Attorney: ☐ Yes ☐ No Location_____
Do Not Resuscitate Order: ☐ Yes ☐ No Location_____

Name of Medication	Dose mg/ml/mcg	Number of times/day

Other Medical/Mental Health Considerations:

_____

_____

_____

Disabilities:_____

Language spoken: _____

HealthLink

Baseline Function:

Mobility	Transfers	ADL's	Feeding
☐walking independently	☐Independent	☐Independent	☐Independent
☐uses walker	☐1 person assist	☐prompting/cueing	☐Supervision/cueing
☐Uses wheelchair	☐2 person assist	☐1 person assist	☐Modified diet
☐Uses scooter	☐Mechanical lift	☐2 person assist	☐Assistance

Baseline Cognition:

Cognition	Behaviours	Speech
☐Intact	☐Resisting Care	☐Intact
☐Modified Independent	☐Physically aggressive	☐Slurred speech
☐Minimally Impaired	☐Socially disruptive/inappropriate	☐Difficulty understanding others
☐Moderately impaired	☐Alcohol Consumption:	☐Difficulty expressing self
☐Severely Impaired	☐Low ☐Moderate ☐High	☐Non-verbal

Home Environment:

Home set up:	☐Stairs	☐Stair lift	☐Transfer aids	☐Bathroom equip	☐Mobility aids
Living Arrangements:	☐Alone	☐Spouse	☐With family	☐Assisted living	☐Retirement home

Current Supports in home environment:

CCAC	Assisted living/HUB	Retirement Home	Private Pay/Family Support	Mental Health Services
	Name:	Name:	Name:	☐Halton Senior Mental Health Outreach
	_____	_____	_____	
☐PSW Freq:	Contact:	Contact:	Contact:	☐Summit House
	_____	_____	_____	☐Support and Housing Halton
☐RN	☐None	☐Independent living	☐Personal care	☐CMHA
☐RRTT	☐Personal care	☐Secure unit	☐Homemaking	☐JBH Mental Health Outreach
☐PT	☐Homemaking	☐Medication assist	☐Behavioural supports	☐BSO
☐OT	☐Medication cueing	☐Assisted living	☐Meal prep or delivery	☐Alzheimer's Society
☐SLP	☐Meal preparation	☐ADL assistance	☐24 hr monitoring service	Other:
☐SW	☐Emergency response		☐Veteran affairs	_____
☐Dietary	/security checks		☐Adult Day Program	Contact:
			_____	_____

**** If you need an increase in care (in addition to above), please contact the health care provider/organization***

Please keep this Emergency Information Vial form up to date with any changes.
To print a new form or get a new emergency information vial, please visit
halton.ca/emergencyvial or dial 311.