

MY EMERGENCY INFORMATION

FULL LEGAL NAME:

DATE OF BIRTH:

PHONE NUMBER:

HOME ADDRESS:

CURRENT MEDICAL INFORMATION

PLEASE REVIEW EVERY 6 MONTHS

LAST UPDATED:

CURRENT MEDICAL CONDITIONS:

ALLERGIES/ SPECIAL HEALTH CONSIDERATIONS:

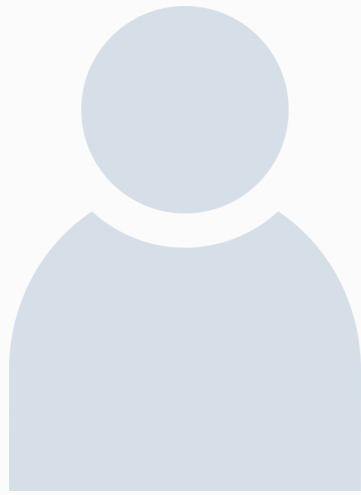
MEDICATIONS LISTED ON SEPARATE RED FILE FORM

PREVIOUS MEDICAL HISTORY

LAST UPDATED:

LIST CONDITIONS YOU HAVE BEEN TREATED FOR IN THE PAST AND DATES:

LIST PAST SURGERIES AND DATES:



Insert Current Picture 2.5" X 3"

DNR/POST ORDER?

CHECK BOX

(DO NOT RESUSCITATE)

LOCATION OF DOCUMENT:

HOSPITAL CHOICE:

BLOOD TYPE:

LIVING WILL?

CHECK BOX

LOCATION OF DOCUMENT:

DURABLE MEDICAL

CHECK BOX

NAME/PHONE/ADDRESS:

LOCATION OF DOCUMENT:

ADDITIONAL ADVANCED DIRECTIVES?

Complete this form and keep it in your *Red File* at all times. Keep this form current by updating your emergency medical information often. Place your *Red File* on your refrigerator for quick access by first responders and emergency personal. Bring your *Red File* with you to any visit to the hospital or emergency care center. Print this form and other Operation Red File forms at www.eastidahoaging.com/OperationRedFile.

EMERGENCY CONTACTS

NAME & RELATIONSHIP/ PHONE:

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YOUR DOCTORS & PROVIDERS

LIST YOUR DOCTORS' & PROVIDERS' NAMES AND CONTACT INFORMATION:
(INCLUDE REASON FOR TREATING YOU)

HOME HEALTH / HOSPICE CARE & DIALYSIS CARE

HOME HEALTH / HOSPICE PROVIDER & CONTACT INFO:

DIALYSIS PROVIDER & CONTACT INFO:

ADDITIONAL INFORMATION

<u>GENDER:</u>	<u>HEIGHT/WEIGHT:</u>	<u>HAIR COLOR:</u>	<u>EYE COLOR:</u>	<u>PRIMARY LANGUAGE:</u>
<u>DEAF/HARD OF HEARING?</u>	<u>HEARING AIDS?</u>	<u>GLASSES/CONTACTS?</u>	<u>BLINDNESS?</u>	<u>DENTURES?</u> UPPER LOWER

ASSISTIVE DECIVES:

IDENTIFYING MARKS/ TATTOOS:

DIETARY RESTRICTIONS:

MISC. INFORMATION: