THE HEALTH PLAN ENVELOPE OF LIFE

*Completion of this form will provide valuable information to medical personnel such as an EMT, Paramedic, or an Emergency Room Doctor in the event of an emergency.

Name: Date of Birth:

Address: City: State: ZIP:

Home Phone: Cell Phone: Blood Type: ☐ Male ☐ Female

Primary Language Spoken: Religion/Church Affiliation:

Do you wear? (check all that apply): ☐ Glasses ☐ Contact Lenses ☐ Dentures/Partials ☐ Hearing Aid(s)

Are you? (check all that apply): ☐ Blind ☐ Deaf ☐ Hard of Hearing ☐ Pregnant

Normal Mental Status (check one): ☐ Alert/Oriented ☐ Alert/Some Impairment ☐ Confused/Disoriented

Do you have Advance Directives?: ☐ Yes ☐ No Living Will (location):

☐ Medical Power of Attorney Name: Phone:

EMERGENCY CONTACTS

Name:	Phone:	Cell Phone:	Relationship:
Name:	Phone:	Cell Phone:	Relationship:

ALLERGIES

Medication Allergies?: ☐ No ☐ Yes List:

Food/Latex/Other Allergies?: ☐ No ☐ Yes List:

MEDICAL CONDITIONS
(check all that apply)

☐ Diabetes	☐ Heart Disease	☐ High Blood Pressure	☐ Arthritis
☐ Kidney Disease	☐ Seizures	☐ Lung Disease/Asthma	☐ Confusion
☐ Stroke(s)	☐ Cancer	☐ Paralysis/Weakness	☐ Bladder Disorder
☐ Nervous Disorder	☐ Liver Disorder	☐ Gastrointestinal Disorder	☐ Bleeding Disorder
☐ Other List:			

MEDICAL DEVICES
(check all that apply)

☐ Pacemaker	Brand:	☐ Stents
☐ Defibrillator	Brand:	☐ Greenfield Filter
☐ Prosthetics (including hip & knee replacements)	Location:	☐ Cerebral Shunt
☐ Hemodialysis Catheter	Shunt Location:	☐ Oxygen Therapy
☐ Peritoneal Dialysis	Catheter Location:	☐ Other (list below):

PROVIDERS

Preferred Hospital: Phone:

Primary Care Physician: Phone:

Specialist: Phone:

Specialist: Phone:

INSURANCE

Medicare #: Medicaid#:

Primary Insurance: Group: Policy #:

MEDICATIONS

Medication Name	Strength	Dosage	Time (check all that apply)
			☐ AM ☐ Noon ☐ PM
			☐ AM ☐ Noon ☐ PM
			☐ AM ☐ Noon ☐ PM
			☐ AM ☐ Noon ☐ PM
			☐ AM ☐ Noon ☐ PM
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			☐ AM ☐ Noon ☐ PM

Medications continued on a separate page? ☐ Yes ☐ No

Where in your residence do you keep your medications?

OTHER INFORMATION

List any other information, including recent surgeries and/or infections in the last 12 months, which may be useful to emergency responders:

Signature Date of Birth