easterseals
Capital Region & Eastern Connecticut

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 Is the patient at risk for wandering? Yes No

☐ **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 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 _____ Caucasian

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