



Emergency Information Form

Date completed: _____

PERSONAL INFORMATION

Name: (First, Middle, Last) _____

Date of Birth: _____

BC Health Card #: _____

Address: _____

Phone number(s): _____

First Language: _____

Are you an organ donor registered with BC Transplant? YES NO

My faith/religion may affect my medical treatment decisions: YES NO

Is there anything first responders need to know about your household if you are taken to hospital?
For example, do you have dependents? If so, who can be contacted to take care of them?

Please provide details:

EMERGENCY CONTACTS

I have a Representation Agreement that designates a decision maker: YES NO

MY REPRESENTATIVE and/or emergency contacts are:

Name	Phone	Relationship

*(If you do not have a Representation Agreement, please review the information about **Temporary Substitute Decision Makers** in the information booklet and complete the Temporary Substitute Decision Makers form)*

HEALTH CARE PROVIDERS

Family Doctor or Nurse Practitioner

Name

Phone

Specialist Doctor

Name

Phone

HEALTH INFORMATION *(e.g. medical conditions, surgeries and anything else you think it is important to know)*

ALLERGIES: (specify)

IMPLANTS: (specify)

ADVANCE CARE PLAN FORMS

Please check forms you have prepared and put in your Green Sleeve:

- Emergency Information Form
- Prescription List from Pharmacist
- MOST form **OR** No CPR (Cardiopulmonary Resuscitation)
- Advance Directive or Personal Wishes Statement
- Representation Agreement **OR** Substitute Decision Makers List

MEDICATIONS *(list name and dosage below, or ask your pharmacist for an updated list to attach to this form)* **KEEP YOUR MEDICATION LIST UP TO DATE**