Emergency Medical Information

Complete the attached form and keep it in the Emergency Medical Information Kit's plastic bag.

You may choose to keep the bag on your refrigerator where trained emergency responders can find this information. If you need to go to the hospital or evacuate your home, you can take the 911SmartPak with you.

You may want to add these items to your Emergency Medical Information Kit:

1. Recent photos of you, your family, and animals.
2. Your Living Will, Advanced Directive, Do Not Resuscitate orders (DNR), Physician Orders for Life Sustaining Treatment (POLST), or similar documents. These documents must be original and signed for emergency responders or doctors to act on your instructions.
3. A list of your current medications with the name of your pharmacy.

Sign up for Smart911™!

Smart911 is available nationwide in towns that have chosen it for their 911 centers. Some counties in Montana use Smart911, including Missoula. Smart911 lets emergency responders briefly see your emergency medical information when you call from a telephone number that you link to Smart911 when you set up an account. This helps emergency medical services provide the best care for you.

The attached emergency medical information form was prepared by Smart911. You, a friend, or a care giver can use this information to make signing up for Smart911 easy.

To learn more, go to this website: www.Smart911.com

To learn more about how to prepare yourself and your family for emergencies and disasters, go to: www.ready.gov/build-a-kit

UNIVERSITY OF MONTANA

Living well under the Big Sky... MONTANA Disability & Health PROGRAM

MONTANA DPHHS

August 28, 2015

Emergency Medical Information Form

Effective date of plan:

Name (First, Middle Initial, Last Names):

Home Address (Street, City, State, Zip code):

Home Phone Number (landline):

Cell/mobile Phone Number:

Email Address:

Emergency contact persons – at least one person who will check in on me in an emergency.

Relationship:

Name (First, Middle Initial, Last Names):

Address (Street, City, State, Zip code):

Home Phone Number:

Cell Phone Number:

Email Address:

Primary Health Care Provider: Name/Number:

Alternate Emergency contact persons—someone different than the emergency contact above

Relationship:

Name (First, Middle Initial, Last Names):

Address (Street, City, State, Zip code):

Home Phone Number:

Cell Phone Number:

Email Address:

Alternate Emergency contact persons-- someone different than the emergency contact above

Relationship:

Name (First, Middle Initial, Last Names):

Address (Street, City, State, Zip code):

Home Phone Number:

Cell Phone Number:

Email Address:

Date of Birth (Month, Day, Year):

Male ☐ **Female** ☐

Height:

Weight:

Hair Color:

Eye Color:

Other physical description information:

This person has difficulty communicating in English (check all that apply):

Unable to speak ☐ **Non-English Speaker** ☐ **Must use Assistive Device** ☐

Blood Type:

◯ **O+** ◯ **A+** ◯ **B+** ◯ **AB+**

◯ **O-** ◯ **A-** ◯ **B-** ◯ **AB-**

Religion:

Enclosed photos of: Self ☐ **Family** ☐ **Animals** ☐

Do you have access to private transportation in the event of an evacuation? Yes ◯ **No** ◯

Driver's License Number:

Make/model/license plate number of vehicle(s):

ADA Accessible Private Vehicle: Yes ◯ No ◯

Are you a trained, certified or licensed health care worker: Yes ◯ No ◯

If yes, list your credentials/certifications/licenses:

Are you at risk of domestic violence? Yes ◯ No ◯

You may provide a Pin# so the 911 Operator can verify your identity:

Medical Information

Allergies:

Indicate the type of prior reaction with an “M” for mild reactions and an "L" for potentially lethal reactions.

- ☐ Aspirin
- ☐ Codeine
- ☐ Demerol
- ☐ Food Allergies
- ☐ Horse Serum
- ☐ Insect Stings
- ☐ Latex
- ☐ Lidocaine
- ☐ Morphine
- ☐ Novocaine
- ☐ Penicillin
- ☐ Sulfur
- ☐ X-ray dyes

Other allergies:

Breathing problems:

- ☐ Asthma
- ☐ COPD
- ☐ Congenital/chronic upper airway disease
- ☐ Cystic fibrosis
- ☐ Emphysema

Other breathing problems:

Cancer:

- ☐ Leukemia
- ☐ Lymphomas

Other cancer:

Catheters & feeding tubes:

- ☐ Feeding tubes
- ☐ Foley catheter
- ☐ Intravenous lines
- ☐ Medication port

If use any of the above, how frequently do these supplies require replacement?

- ☐ Daily
- ☐ 2 times/week
- ☐ weekly
- ☐ every other week
- ☐ monthly

General Medical Conditions:

- ☐ Adrenal insufficiency
- ☐ Alcoholism
- ☐ Blood clotting–disorder
- ☐ Chronic pain
- ☐ Depression
- ☐ Diabetes
- ☐ Eye surgery
- ☐ Glaucoma
- ☐ Hemophilia
- ☐ Hypertension
- ☐ Malignant hypertension
- ☐ Malignant hyperthermia
- ☐ Muscular dystrophy
- ☐ Myasthenia gravis
- ☐ Renal failure/hemodialysis
- ☐ Rheumatologic/joint problems
- ☐ Sickle cell anemia
- ☐ Situs inverse
- ☐ Stroke
- ☐ Suicide attempt

Heart Disease:

- ☐ Aortic aneurysm
- ☐ Angina
- ☐ Cardiac dysrhythmia (abnormal heart rate)
- ☐ Congenital heart failure
- ☐ Congestive Heart Failure (CHF)
- ☐ Coronary artery bypass/angioplasty
- ☐ History of heart attack/Myocardial infarction
- ☐ History of myocarditis/Pericarditis/ heart infection
- ☐ Pulmonary hypertension

Mobile Limitations:

- ☐ Amputee
- ☐ Confined to bed
- ☐ Electric wheelchair or scooter
- ☐ Manual wheelchair
- ☐ Paraplegia
- ☐ Quadriplegia
- ☐ Require walker, cane, or crutches
- ☐ Require wheelchair
- ☐ Weight over 300 pounds

Other mobility impairment:

Neurological, Behavioral, Cognitive Conditions:

- ☐ Anxiety (extreme)
- ☐ Autism spectrum disorder
- ☐ Bipolar disorder
- ☐ Cerebral palsy
- ☐ Cognitive impairment
- ☐ Confused easily
- ☐ Developmental disability
- ☐ Developmentally delayed
- ☐ Difficulty understanding verbal or written instructions
- ☐ Intellectual Disability

- [ ] Memory impaired, dementia, Alzheimer's
- [ ] Migraine or frequent headaches
- [ ] Neurological disease
- [ ] PTSD
- [ ] Prone to wandering
- [ ] Seizure disorder/epilepsy
- [ ] Schizophrenia

Other psychiatric conditions:

Organ transplants:

- [ ] Bone marrow
- [ ] Bowel
- [ ] Heart
- [ ] Kidney
- [ ] Liver
- [ ] Lung
- [ ] Pancreas

Powered Medical Devices:

- [ ] Apnea monitor
- [ ] IV pump
- [ ] Kidney dialysis
- [ ] Life sustaining medication requiring refrigeration
- [ ] Nebulizer for breathing problems
- [ ] Oxygen concentrator
- [ ] Sleep apnea, CPAP, BRAP device
- [ ] Ventilator/Respirator

Other life-sustaining device or equipment dependent on electricity:

Prescription Medications:

- [ ] Antiarrhythmic
- [ ] Anticoagulant/blood thinner
- [ ] Antihistamine (regular use)
- [ ] Antianginal
- [ ] Anti-psychotic
- [ ] Anti-seizure
- [ ] Beta blocker
- [ ] Chemotherapy
- [ ] Diabetes medication (oral)
- [ ] Erectile dysfunction medication
- [ ] Immune suppressant
- [ ] Insulin
- [ ] Narcotics (regular use)
- [ ] Steroid (oral)

Other prescription medication:

Sensory Impairments (vision, hearing and speech) and Assistive Technology:

- ☐ Blind
- ☐ Deaf/blind
- ☐ Braille
- ☐ Computer
- ☐ iPad
- ☐ Deaf
- ☐ Hard of hearing
- ☐ Hearing aids
- ☐ Batteries
- ☐ Cochlear Implant (external/removable parts of the C.I. system)
- ☐ Interpreter
- ☐ Speech impaired
- ☐ Nonverbal
- ☐ Augmentative or Alternative communication Device

Other Medical information:

Glasses or contact lenses: Yes ◯ No ◯

Organ donor: Yes ◯ No ◯

Advance directive: Yes ◯ No ◯

If yes, where is it located?

Hospital preference:

Main Direct Care or Support person(s) Name/Number:

Implanted Medical Devices:

- ☐ Artificial joints
- ☐ Cochlear implants(s)
- ☐ Heart valve prosthesis/artificial heart valve
- ☐ Implanted defibrillator
- ☐ Left Ventricular Assist Device (LVAD)
- ☐ Pacemaker
- ☐ Tracheotomy
- ☐ Insulin Pump

Medical Therapies and Equipment:

☐ Home health care/visiting nurse/non-medical caregiver:

Agency or Name/number:

☐ Home health care/Visiting nurse/Non-medical caregiver (around-the-clock):

Agency or Name/number:

☐ In-home sustaining medication or treatment

☐ Requires airway suctioning

☐ Uses oxygen tank

Note. This form is also available in an electronic, accessible format at this web address: http://mtdh.ruralinstitute.umt.edu/blog/?page_id=123.