CAREGIVER
Emergency Readiness Pack

Complete and post on refrigerator; take a picture of this document and keep in your phone

MEDICAL HISTORY

NAME: _____ NICKNAME: _____

SPOUSE NAME: _____ CELL NUMBER: _____

DATE OF BIRTH: _____ RELIGIOUS PREFERENCE: _____

INSURANCE: _____ INSURANCE NUMBER: _____

DRUG ALLERGIES: _____ FOOD ALLERGIES: _____

HEIGHT: _____ MARKS/SCARS: _____

WEIGHT: _____ L/R SIDE OF BODY: _____

DIAGNOSIS: _____

MEDICATIONS: _____

MEDICAL PROVIDERS

PRIMARY PHYSICIAN NAME: _____ PHONE NUMBER: _____

PHARMACY NAME: _____ PHONE NUMBER: _____ FAX: _____

HOSPITAL PREFERENCE: _____

REHAB/SKILLED NURSING PREFERENCE: _____

SONATA REPRESENTATIVE: _____ PHONE NUMBER: _____

HOME HEALTH CARE PREFERENCE: _____

LEGAL

POWER OF ATTORNEY: YES / NO (see attached) WILL AVAILABLE: YES / NO (see attached)

NAME OF POWER OF ATTORNEY: _____

PHONE NUMBER: _____

CPR STATUS: _____ DO NOT RESUSCITATE _____ N/A

I have chosen the above providers to assist with my healthcare needs if I am hospitalized.

SIGNATURE _____ DATE _____

Sonata
Senior Living