Emergency Information Form

Date Completed: _____

PERSONAL INFORMATION		
Name: (First, Middle, Last):		
Date of Birth:		
BC Health Card #:		
Address:		
Photo number (s):		
First Language:		
Are you an organ registered with BC Transplant? ☐ Yes ☐ No		
Is there anything first responders need to know about your household if you are taken to the 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 Representative 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):

ADVANCE CARE PLAN FORMS
Please check off any additional forms you have put in this Green Sleeve: ☐ Prescription list from pharmacist ☐ MOST form regarding no CPR (must be signed by a doctor) ☐ Advance Directive and/or Personal Wishes Statement ☐ Representative Agreement ☐ 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 UP TO DATE