Client Emergency Information

Client's Name: ______ Medicaid Number: ______

Client's Address: ______

Client's Telephone: ______ Fax: ______

Advance Directive Information

Type of Advance Directive on File: ______

Medical Information

Physician's Name: ______

Physician's Telephone: ______ Fax: ______

Client's Hospital Preference: ______

Known Medication Allergies/Pertinent Medical Information

Allergies:

______

Diagnosis:

______

Medications *(to be Updated if client is sent to hospital)*

Client Representative or Family Members/Emergency Contacts:

1.	Relationship:	Home Phone: Work Phone: Other:
2.	Relationship:	Home Phone: Work Phone: Other:
3.	Relationship:	Home Phone: Work Phone: Other:

Review Dates: *(information must be reviewed for changes at least annually)*. Record the date of review or any time changes made to the information.