SENIOR PLUS HEALTHCARE INC.

EMERGENCY PROCEDURE SHEET

Date Initiated: ________________

Consumer's Name: ____________________________ *D.O.B* ________________________

Medicaid # ____________________________ *Medicare #* ____________________

Address: ____________________________ *Social Security #* ________________

City: ____________________________ *State* _____ *Telephone #* ___________

DIRECTIONS TO CONSUMER'S HOME: ____

____

____

____

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Physician's Name: ________________________ *Address:* ________________________

City: ________________________ *State* ____ *Telephone #* ________________

Next to Kin: ________________________ *Relationship:* ________________________

Address: ________________________ *Telephone:* ________________________

Diagnosis: ____

MEDICAL ALERT ____

(Medications listed on next page)

Consumer Limitations / Special Instructions: ______________________________

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Hospital of Choice: ____________________________ *Telephone:* ________________
Ambulance Service: ____________________________ *Telephone:* ________________
Preferred Pharmacy: ____________________________ *Telephone:* ________________

ADVANCE DIRECTIVES: Yes ___ *(IF YES SEE ATTACHED) NO* ____

CLIENT AUTHORIZATION:

I ______________________, *hereby authorize Senior Plus Healthcare, Inc. staff or designee to seek Emergency Medical Treatment and transportation.*
I understand that I am responsible for the cost of the emergency care.

Signature: ________________________________ ***Date:*** ______________

Senior Plus HealthCare INC.
HR@SeniorPlusHealthCare.com
1127 Brown Ave, Columbus Ga. 31906 Office: 706 649 6777 Fax: 706 649 6780

SENIOR PLUS HEALTHCARE INC.

MEDICATIONS

Medications	*Dosage*	*Route*	*Time*	*Prescribing Physician*

Has there been any change in medication? (   ) Yes or (   ) No

(   ) Updated ________

____

Registered Nurse (RN) / Date

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