Glacier County Integrated Mobile Health

Emergency Information Form

Name:	Birthdate:
Home Address:	Home/Work Phone:
Parent/Guardian: (if needed)	Signature/Consent*:
Emergency Contact Names and Relationship:	Emergency Contact Phone Number(s):

*consent for release of this form to health care providers

Physicians:

Primary Care Physician:	Emergency Phone:
	Fax:
Current Specialty Physician: Specialty:	Emergency Phone:
	Fax:
Current Specialty Physician: Specialty:	Emergency Phone:
	Fax:
Anticipated Primary ED:	Pharmacy/Phone Number:
Anticipated Tertiary Care Center (Hospital with highest level of care):	

Immunization Dates (mm/yy):

DPT ___ OPV ___ MMR ___ HIB						Hep B ___ Varicella TB status Other				

Antibiotic prophylaxis (prevention with antibiotics):
Yes / No (circle)

Indications (diagnosis):
____
____
____

Medication and dose:
____
____
____

Diagnoses/Past Procedures/Physical Exam:

1. ____________________
2. ____________________
3. ____________________
4. ____________________

Synopsis (Summary): ____________________

Baseline physical findings: ____________________

Baseline vital signs: ____________________

Baseline neurological status: ____________________

Medications:
1. ____________________
2. ____________________
3. ____________________
4. ____________________
5. ____________________
6.

Significant baseline ancillary findings (lab, x-ray, ECG): ____________________

Prostheses/Appliances/Advanced Technology Devices: ____________________

Management Data:

Allergies: Medications/Foods to be avoided	Side Effects:
1.	
2.	
3.	

Procedures to be avoided:	Side Effects:
1.	
2.	
3.	

Common Presenting Problems/Findings, with Specific Suggested Managements:

Problem:	Suggested Diagnostic Studies:	Treatment Considerations:

Comments on Client or Other Specific Medical Issues:

____

Physician/Provider Signature:	Print Name: