Form Revised: 10/24/2013

EMERGENCY MEDICAL INFORMATION

DANE COUNTY
Transitions of Care

The purpose of this form is to help assure that important information about you is given to emergency room/hospital staff at time of admission. Please complete both sides of this medical information form and place it where it can be easily found, if needed. It is recommended that you share a **copy** of this form with a family member who is involved in your care. Check the boxes below that best describe your situation. Please give your completed form to the emergency room/hospital **at your time of arrival.**

My Name Is: _____

Date of Birth: _____ **Date I Completed This Form:** _____

I came to the emergency room from: ☐ Home ☐ Assisted Living
☐ Other Facility Name: _____

I have the following home care and/or community services involved in my care (List all involved): _____

_____

I have the following major medical diagnoses: _____

_____

My baseline abilities are: ☐ Confused ☐ Not feeling confused

I will follow basic directions: ☐ Yes ☐ No

I am safe to walk: ☐ No ☐ With cane or walker
☐ With cane or walker and assistance ☐ I can walk safely

I can communicate best:
☐ With glasses ☐ With hearing aid
☐ I can hear, see and understand without help
☐ Can respond verbally, but not with reliable information ☐ Cannot speak

☐ **I need someone to communicate information for me. Please call:**
Name: _____
Phone: _____
My: ☐ **Relative/Friend** ☐ **Health Care Power of Attorney**
☐ **Translator because I speak** _____

My Primary Care Doctor/Nurse Practitioner is: _____

I use the following pharmacy: _____

Do not discharge me before calling the person who coordinates my care:
Name/Agency: _____
Phone: _____

PLEASE COMPLETE THE PERSONAL MEDICATION RECORD ON THE REVERSE SIDE

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Personal Medicine Record for: _____

Directions:

- Use a pencil
- If you are entering a medication like an antibiotic that is taken for a limited amount of time, remember to remove it from the list when the doses are finished
- List <u>all</u> other medications taken, including prescriptions, eye drops, inhalers/nebulizers, oxygen, creams and ointment, etc.

Date Added or Changed	Medicine Name	How much? (Strength/Dose)	How often do I take it?	What is it for?	Doctor who Prescribed it

Over-the-Counter Medicines (medicine you can buy without a doctor's order): **(Check all that you take regularly)**

☐ Allergy medicine, antihistamines ☐ Cold/cough medicines ☐ Laxatives
☐ Antacids (for heartburn or stomach) ☐ Diet Pills ☐ Sleeping Pills
☐ Herbals, dietary supplements, hormones ☐ Aspirin ☐ Vitamins, minerals
☐ Pain, headache or fever medicine ☐ Other (List): _____

**** Emergency room staff make a copy of this form for patient's medical record.**
Please give original back to patient/caregiver.