Essential Information for Emergency Department (ED)

Name: _____ Gender: ____
(last, first)

Address: _____

Tel. No: _____

DOB (dd/mm/yyyy): _____

Health Card Number: _____

CLIENT INFORMATION

Prefers to be called:

Lives with: ☐ **Family** ☐ **Group home** ☐ **Foster home** ☐ **Independent** ☐ **Other**

EMERGENCY CONTACT INFORMATION:

Name: **Relationship:**

Tel #: Home: **Work or cell:** Substitute Decision Maker ☐ **Yes** ☐ **No**

HEALTH AND SOCIAL AGENCY CARE PROVIDERS:

Family Physician: **Tel. #:**

Psychiatrist: **Tel. #:**

Case Manager: **Agency:**

Name: **Tel. #:**

Preferred hospital / treatment centre:

Other agencies involved, contact person's name **Tel. #:**

REASON FOR REFERRAL TO ED: Safety risks to self, others or environment? ☐ **No** ☐ **Yes** (specify):

_____

_____

_____

BRIEF OVERVIEW OF HEALTH STATUS: Include diagnoses, allergies, etiology of developmental disability (DD) & level of functioning, health issues and risks – physical and behavioural or mental health

_____

_____

_____

_____

Special needs: _____

NB: ATTACH LIST OF CURRENT MEDICATIONS ☐ **attached**

Copy of Medication Administration Record (MAR) or List from Pharmacy, and send or bring medications

Signature: _____ **Date:** _____
Print Name, Designation dd/mm/yyyy

Best contact #: _____

