

**DRAFT**  
**GHC ELECTRONIC MEDICAL HOME CARE PLAN 11/16/05**

**EMERGENCY CARE PLAN**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Date Created: \_\_\_\_\_

GHC # \_\_\_\_\_

UW # \_\_\_\_\_

Primary MD: \_\_\_\_\_

SPECIAL NOTES	
I like to be called _____	
The language I use: _____	
I like eye contact:	<input type="checkbox"/> YES <input type="checkbox"/> NO
I can be touched:	<input type="checkbox"/> YES <input type="checkbox"/> NO
I am:	<input type="checkbox"/> Non-Verbal <input type="checkbox"/> Deaf <input type="checkbox"/> Blind
Communication Aides: _____	
I like it best when you: _____	
Language age level:	Receptive: _____ Expressive: _____
Participate in decisions about health care <input type="checkbox"/> YES <input type="checkbox"/> NO	

<p><b>Family Contact:</b>          Patient lives with:          Relationship:          Address:          Telephone: (H)                            (W)                            (C)          Health Insurance Plan ID#</p>	<p><b>Emergency Contact:</b>          Name:          Relationship:          Address:          Telephone (H)                            (W)                            (C)</p>
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Custody or other restrictions:     Guardianship     Power of Attorney     Other  
Emergency Contact person: \_\_\_\_\_

Code Status: Advance directives exist     Y     N    Comments: \_\_\_\_\_

Medical release for:  
School:     Yes     No    Clinic:     Yes     No    Nursing Home:     Yes     No

**PE Findings/ Special Family Needs/Requests (ex., Communication or Transportation needs)**

**PERTINENT EMERGENCY HISTORY/ PHYSICIAN DATA**

(Ex. BP Difficult to measure; Premie/Wt.; Car Accident/date)

OTHER Comments:

Current Vital Signs (baselines) Pertinent Physical Exam Findings Date: \_\_\_\_\_

Ht \_\_\_\_\_ Wt \_\_\_\_\_ Pulse \_\_\_\_\_ Rhythm \_\_\_\_\_

Resp \_\_\_\_\_ Oximetry \_\_\_\_\_ BP \_\_\_\_\_ Other \_\_\_\_\_

Blood Disorders: None HIV HBV HCV Hemophilia Other

<b>BRIEF PERTINENT HISTORY</b> Snapshot for unfamiliar providers	<b>Specialist Phone</b>	<b>Pager#</b>	<b>CPT Code</b>

**MEDICATIONS**

Allergies/Reaction \_\_\_\_\_ Date of Onset \_\_\_\_\_  
 Latex/Reaction \_\_\_\_\_ Date of Onset \_\_\_\_\_

Medications	Dose/Frequency	Date prescribed	Last drug level/INR's

Alternative Therapy (i.e. Acupuncture, Chiropractor, Herbal Medications)

**NUTRITION ISSUES**