ABOUT MY LOVED ONE

Full name _____ Date of birth _____

Address _____ Phone _____

Preferred hospital _____ DNR on file? ☐ Yes ☐ No Kept at: _____

HEALTH CONDITIONS / DIAGNOSES

ALLERGIES

INSURANCE

Plan _____

Member ID _____

Group # _____

Phone _____

PHARMACY

Name _____

Phone _____

Address _____

LEGAL DOCUMENTS (WHERE THEY ARE KEPT)

Power of attorney _____

Health care proxy _____

Living will _____

Will _____

DAILY NEEDS AND PREFERENCES