

EMERGENCY ROOM/HOSPITAL ADMITTANCE FORM

Form to be completed by residential staff prior to bringing the individual with mental retardation to the Emergency Room or admitting the individual to the hospital.

Date: _____ Completed by: _____ Relationship to Individual: _____

Name: _____ Nickname/Likes to be called: _____

DOB: _____ Soc Sec #: _____

Address: _____

Phone #: _____

Health Insurance (Type & Numbers)

Primary: _____

Secondary: _____

Allergies: _____

Living Status: Group Home _____ Family Living _____ Lives Independently _____ Other _____

Nursing Supports Available at provider agency? (circle) Yes or No; RN and/or LPN Name: _____

Emergency Contacts

Name (Provider Agency): _____ Name (Family): _____

Phone Number: _____ Relationship: _____

Phone Number (After Hours): _____ Phone Number: _____

County Contact Person: _____

Phone Number: _____

Phone Number (After Hours): _____

Primary Care Physician: _____

Phone Number: _____

Reason for ER visit today:

Neurologist: _____

Phone Number: _____

Current Medical Problems/Diagnoses:

Psychiatrist: _____

Phone Number: _____

Level of Mental Retardation (circle one):

Mild Moderate Severe Profound

Consent Status:

- CAN give own consent
- CANNOT give own consent. Has a Legal Guardian.

Legal Guardian: _____ Phone Number: _____

- CANNOT give own consent. Does not have a Legal Guardian. Has a Substitute Healthcare Decision Maker.

Name: _____ Phone Number: _____

Medical Durable POA: _____ Phone Number: _____

Resuscitation Status:

- DNR****
- Full Resuscitation

If DNR, List Reason: _____ Date DNR Given: _____ By Whom: _____

Consent for Release of Information to Provider(circle one): Yes No

Date of Last Tetanus: _____ Date of Last PPD: _____ Date of Last Flue Shot: _____

Date of Last Pneumovax: _____ Date of Hepatitis B Vaccines: _____

