

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

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