

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 #: _____

Health Insurance (Type & Numbers)

Address: _____

Primary: _____

Phone #: _____

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): _____

Phone Number: _____

Phone Number (After Hours): _____

Name (Family): _____

Relationship: _____

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: ¹ ² ³ ⁴

☐ 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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H Kauffman



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