

INDIVIDUALIZED EMERGENCY PLAN

Priority Code: _____ High Medium Low
Name: _____ **ID #:** _____ Female Male
Phone #: _____ **Cell phone #:** _____
Address: _____
Significant diagnoses: _____
Date of birth: _____ **Age:** _____ **Blood type:** _____ **Advance Directives:** No Yes (attach copy if applicable)
List of medications: No Yes (copy attached) **Allergies:** _____

Emergency Contacts and/or Next of Kin (if applicable):
Name: _____ **Relationship to patient:** _____
Address: _____ **Phone #:** _____
Name: _____ **Relationship to patient:** _____
Address: _____ **Phone #:** _____
Certifying Physician: _____ **Phone #:** _____
Secondary Physician: _____ **Phone #:** _____
Primary Caregiver: _____ **Phone #:** _____
Representative(s) or Person(s) with POA (if any): _____ **Phone #:** _____

Emergency Phone Numbers:

SERVICE TYPE	NAME	PHONE #
Police		
Fire department		
Preferred hospital		
Preferred ambulance		
Preferred pharmacy		
Heating company		
Water company		
Electric company		
DME/Supplies		
DME/Supplies		

In the Event of Tornado: The best place to shelter/take refuge in the home is: _____
 Can patient reach this area independently: Yes No If No, will be assisted by: _____
In the Event of Evacuation: Patient prefers to: stay home go to public shelter go to a chosen safe place (explain): _____

Mobility level (e.g., wheelchair, bedbound): _____
Special disability needs (eye/hearing aids, language/communication aids etc.): _____

Medical supplies used (e.g., dressings, gloves, syringes): _____

Management of special equipment (e.g., nebulizer, batteries for equipment, portable O₂ tank, IV equipment, walker, insulin pump): _____

Transportation arrangements needed: Yes No **Comment:** _____
Additional information: _____

Keep this information in a safe place where you can grab it quickly, including your emergency kit. You may also consider putting important papers with it in the event you are evacuated, to a safe place. For example, your insurance papers, a copy of your advance directives and identification papers etc. Consider placing your important papers in a plastic zip top bag.

Copies of IEP given to: Patient Caregiver Representative Other: _____

Clinician Signature/Title: _____ **Date:** _____ **Time:** _____