Client Emergency Plan

Client wishes to be addressed as:			
Client Name		Date of Birth:	
Language spoken		Contact number	
Medicare Number	Private Health Insurance		Ambulance membership number
Any hearing Issues? Any speech issues? Is Dementia present? Any Mental Health issues? Dysphagia?	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No		
Pets needing care?	☐ Yes ☐ No	Contact Person	
Emergency Contact 1: Name		**Relationship to client:**	
Contact Number		Enduring Power of Attorney (EPOA)	☐ Yes ☐ No
Emergency Contact 2: Name		**Relationship to client:**	
Contact Number		Enduring Power of Attorney (EPOA)	☐ Yes ☐ No
Advanced Life Directive / End of Life Planning in place? ☐ No ☐ Yes If yes, where is it located?			

MEDICAL HISTORY	
Medical History Diseases/ Conditions/ injuries/ major surgeries	
Known allergies	☐ Medication ☐ Food: ☐ Dressings ☐ Other: ☐ NA
List any sedatives, morphine based drugs or addictive drugs (e.g. cannabis) or Warfarin/ blood thinners you are taking.	
GP contact details	
Pharmacists contact details	
Any additional information? Any needle phobia, fainting? Any aids in use?	
By completing this form, I consent to this information being shared with emergency personnel and other authorised persons where it is necessary for the provision of services and emergency response to me.	
Form completed by: Name:	**Date**