RESIDENT
IDENTIFICATION & EMERGENCY INFORMATION
SUPPLEMENTAL SHEET

Facility Phone Number:_____

PATIENT NAME: _____

DATE OF BIRTH:_____ AGE:_____

DOES THIS PATIENT HAVE A DO NOT RESUSITATE (DNR): YES NO
(If YES, please see attached DNR form)

PHYSICIAN / VENDOR LIST
NAME/PHONE OF PRIMARY PHYSICIAN:_____

NAME/PHONE OF CARDIOLOGIST:_____

NAME/PHONE OF NEUROLOGIST:_____

NAME/PHONE OF OTHER PHYSICIAN:_____

NAME/PHONE OF OTHER PHYSICIAN:_____

HEALTH NOTES
PATIENT ALLERGIES:
_____
_____
_____
_____

BRIEF MEDICAL/HEALTH HISTORY:
_____
_____
_____
_____

ADDITIONAL NOTES:
_____
_____
_____
_____

PLEASE SEE MEDICATION LIST ATTACHED