ATTENTIVE HOME CARE LLC

AUTHORIZATION FOR EMERGENCY PROCEDURE PLAN

Agency 24-Hour Number: 612-447-5958

In the event of a medical or situational emergency, activate my emergency plan as stated below. I authorize you to use your judgment in this matter and arrange for needed transportation and/or services.

CLIENT'S NAME
_____DOB_____

Address_____

City _____ State _____

Phone #_____

PHYSICIAN INFORMATION

Name_____

Phone #_____

Address_____

City _____ State _____

FAMILY MEMBER/EMERGENCY CONTACT:

Name_____

Relationship_____

Address_____

City_____ State _____

Home Phone # _____

Alternate Phone #_____

ALLERGIES:_____

_____

_____

_____

Oxygen/Ventilator Provider:_____

Electric Company: _____

Gas Company:_____

Water Provider:_____

Equipment Provider:_____

Pharmacy:_____

EMERGENCY PHONE 911

HOSPITAL:_____

City: _____

Phone#: _____

ADVANCE DIRECTIVE: ☐ **Yes** ☐ **No**

If Yes, Type:_____

☐ **Do Not Resuscitate**

☐ **Full Resuscitation**

CaseManager:_____

Phone:_____

CLASSIFICATION: (circle one) **Client is LEVEL**

LEVEL 1: No caregiver in home or readily available; dependent on others to meet physical or safety needs – **you are a HIGH PRIORITY for staffing**

LEVEL 2: Use assistive devices – could manage alone for time period of 24-48 hours; able to take medications or get food if available at home. RN will contact to coordinate needs and services. **You will be contacted by the agency by phone.**

LEVEL 3: Able to manage alone for more than 72 hours or has available caregivers or other support systems in place. Manages own medications and diet. **You will be contacted by the agency before your next scheduled visit or shift.**

Client Signature _____ **Date** _____

Witness _____ **Date** _____