Emergency Medical Information Form

VIAL OF LIFE — FILE OF LIFE

Date Completed: _____

NAME:

First	Middle Initial	Last	Date of Birth

MEDICAL CONDITIONS:

- ☐ Diabetes
- ☐ Heart Disease
- ☐ Heart Failure
- ☐ Stroke
- ☐ Asthma
- ☐ COPD
- ☐ Arthritis
- ☐ Cancer
- ☐ High Blood Pressure
- ☐ Alzheimer's Disease/ Dementia
- ☐ Other (please specify)

ALLERGIES (Food, medication and/or environmental)

SURGERIES AND DATES:

Surgery:	Date:	Surgery:	Date:

PHYSICIANS:

Name:	Specialty:	Address:	Phone:

HOSPITAL PREFERENCE:

HEALTH INSURANCE COMPANY:

PETS:

Please contact _____ (Name) at _____ (Phone #) to care for my pet, _____ (Pet's Name).

EMERGENCY CONTACTS:

Name:	Relationship:	Home Phone:	Work Phone:

MEDICATIONS:

Name:	Dosage/Strength:	Quantity:	Purpose/Special Instructions:

ADVANCE DIRECTIVES/LIVING WILL:

Do you have an Advance Directive/Living Will? ○ YES ○ NO

- *Consider filing a scanned copy of your advance directive/living will on the File of Life flash drive.*

Additional forms may be accessed at www.sunhealth.org/vialoflife or by calling (623) 832-5665.