THE LORELTON ASSISTED LIVING FACESHEET

Emergency Information

THIS FORM CONTAINS IMPORTANT INFORMATION NEEDED FOR THE EMERGENCY MEDICAL TEAM IN THE EVENT OF A MEDICAL EMERGENCY.

Name	**Sex**	**Race**	**Marital Status**	**CODE STATUS**

Street Address	**City/Town**	**State**	**County**	**Zip Code**
2200 West 4th Street	Wilmington	DE	NCC	19805

Date of Birth	**Birthplace**	**Religion**	**Move-In Date**	**Apt. #**

Admitted From:	**Usual Occupation**	**Served in U.S. Armed Forces?** Yes No Unknown

Diagnoses on Move In:	*ALLERGIES:*

Next of kin/ POA/ Representative	**Relationship**	**Address**	**Home** **Work** **Cell** **Email**
Person to notify in emergency	**Relationship**	**Address**	**Home** **Work** **Cell** **Email**
Other Significant contacts	**Relationship**	**Address**	**Home** **Work** **Cell**

Social Security Number	**Medicare Number**	**Other Insurance**

Hospital of Choice	Address	**Phone** fax
Attending physician	**Address**	**Phone** Fax:
Dentist	**Address**	**Phone** fax
Podiatrist	**Address**	**Phone Fax**
Additional Health Provider Discipline:	**Address**	**Phone** fax
Additional Health Provider Discipline:	**Address**	**Phone** Fax
Additional Health Provider Discipline:	**Address**	**Phone**
Mortuary Preference:	Address	**Phone**

FINANCIAL RESPONSIBLE PARTY	

THIS FORM DOES NOT CONTAIN MEDICATION INFORMATION AS THE RETIREMENT COMMUNITY CAN NOT ASSUME RESPONISBILTY FOR UPDATING MEDICAL INFORMATION.