VIAL OF LIFE

For non-emergency services or assistance with Vial of Life, please contact Express Ambulance at 619-589-0022 or info@expressambulanceco.com.

Date updated: __________ __________ __________ __________

Name: ____ Gender: M F

Date of birth: _____/_____/_____ Social Security # __________-_______-_________

Preferred language: ____________ Single Married Divorced Widowed I am a parent

Address: ______________________________________ Phone # ______________________

Emergency Contacts:

Name ________________________________ Relationship __________________________

Phone#: home _____________________ cell ___________________ work ___________________

Name ________________________________ Relationship __________________________

Phone#: home _____________________ cell ___________________ work ___________________

Clergy Name ____________________ Faith ___________________ Phone __________________

Child information: *(List your dependent children and special instructions, including a caregiver)*______

____

____

____

____

Pet information: *(List pets and special instructions, including pet-sitter)*________________________

____

____

Medical History:

Height ________ Weight ________ Normal Blood Pressure: _______/______ Blood Type ________

Medical/Insurance Information: *(please include a copy of your insurance card*

HMO/Insurance Co: ______________________ Member # __________________

Medicare # __________________________ Medical Records located at:______________________

Primary Care Physician/Hospital: ______________________________ Phone#_________________

Have you enclosed a:

California Advanced Health Care Directive? **Yes** **No** *Living Will* **Yes** **No**

Durable Power of Attorney form **Yes** **No** *Do Not Resuscitate* (DNR) Order **Yes** **No**

Do you:

Wear dentures? **Yes** **No** Glasses **Yes** **No** Contacts **Yes** **No**

Hearing aids **Yes** **No** Use oxygen? **Yes** **No** Dosage: ______________________________

Have any prosthetics or implants? **Yes** **No** *Please list* ____

____

Drug Allergies (please specify) ____

Other Allergies (food, etc) ____

____

List major medical problems/physical disabilities/conditions *(eg: heart problems, diabetes, asthma, high blood pressure, etc)*: ____

____

____

____

List past surgeries/injuries: ____

____

____

Current Immunizations: ____

Where are your immunization records kept? ____

Medications:

Where do you keep your medications? ____

Current Medications: *(include prescription, over-the-counter, vitamins and herbal supplements)*

Name: _____________________________________ Dosage/Time_______________________________________

Purpose:____

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