

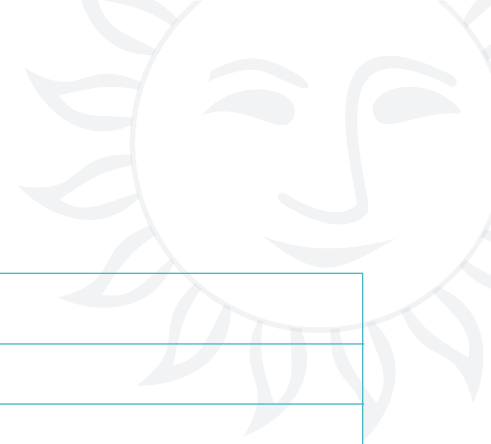
Patient Emergency Preparedness Plan Form

Identifying Information		
Patient Name	SOC Date	
Patient Address		
City	State	Zip
Patient Phone		
Physician #1	Physician # 1 Phone	
Physician #1 Address		
Relevant Healthcare Information		
Daily or more Frequent Agency Services: <input type="checkbox"/> Yes <input type="checkbox"/> No if Yes, please describe		
Oxygen Dependent: Flow Rate	Hrs of Use:	Delivery Dev.
Life-Sustaining Infusion: <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please describe		
Other IV Therapy: <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes describe		
Patient/Careviver Independent: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Ventilator Dependent: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Dialysis: <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please describe		
Tube Feeding: <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please describe		
Patient/Caregiver Independent with Self-Administered Medications: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Functional Disabilities (check all that apply) : <input type="checkbox"/> Walker/Can <input type="checkbox"/> Wheelchair <input type="checkbox"/> Hearing Impairment <input type="checkbox"/> Visual Impairment <input type="checkbox"/> Mental/Cognitive Impairment <input type="checkbox"/> Bed bound <input type="checkbox"/> Tremors		
Personal Emergency Response System: <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please describe		



The Sun Home Health

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Emergency Preparedness Kit (dependent upon geographical needs): N/A		
Water	3-day food supply	Battery-operated radio
Flash light and dry battery	Other (Specify)	
Receipt of Home Safety Evaluation: <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes Date)		
Symptoms to Report		
Additional Emergency Guidelines/Instructions		
Emergency Plan		
Emergency Contact Name		Phone Number
Emergency Contact Relation		
If Necessary, I patient will evacuate to : <input type="checkbox"/> Relative <input type="checkbox"/> Friend		
Evacuation contact Name/Phone Number		
Next of kin Name / phone number		
Hospital of Choice		
Hospital of Choice Address		
Primary Nurse		Pharmacy
Pharmacy Address/Phone		
Fire Department Phone		
Police Department Phone		
Ambulance Phone		
On Call Number		
Priority/Acuity Level		
Clinician		Date