The Sun Home Health

We Believe in Excellence! - Since 1997

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: ☐ Yes ☐ No if Yes, please describe		
Oxygen Dependent: Flow Rate	Hrs of Use:	Delivery Dev.
Life-Sustaining Infusion: ☐ Yes ☐ No If Yes, please describe		
Other IV Therapy: ☐ Yes ☐ No If Yes describe		
Patient/Careviver Independent: ☐ Yes ☐ No		
Ventilator Dependent: ☐ Yes ☐ No		
Dialysis: ☐ Yes ☐ No If Yes, please describe		
Tube Feeding: ☐ Yes ☐ No If Yes, please describe		
Patient/Caregiver Independent with Self-Administered Medications: ☐ Yes ☐ No		
Functional Disabilities (check all that apply) : ☐ Walker/Can ☐ Wheelchair ☐ Hearing Impairment ☐ Visual Impairment ☐ Mental/Cognitive Impairment ☐ Bed bound ☐ Tremors		
Personal Emergency Response System: ☐ Yes ☐ No If Yes, please describe		

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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: ☐ Yes ☐ No (If Yes Date)
Symptoms to Report
Additional Emergency Guidelines/Instructions
Emergency Plan
Emergency Contact Name Phone Number
Emergency Contact Relation
If Necessary, l patient will evacuate to : ☐ Relative ☐ 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