Emergency hospital form

Name

I like to be called

Date of Birth

Address

Telephone number

Emergency contact number and name

Doctors Information

Doctors name

Doctors address

Doctors telephone number

Anyone else to contact

Name of nurse

Medical History

Any illness

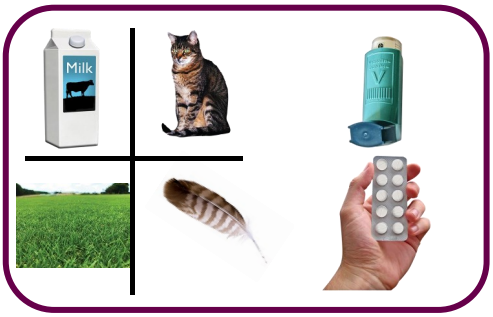
My medicines

How do I take my medicines

Things that make me worry at the doctors or hospital

How to make me feel safe and calm about my worries

My allergies are



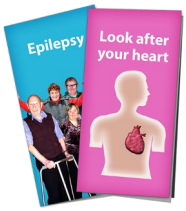
My allergy medicines

My mental capacity

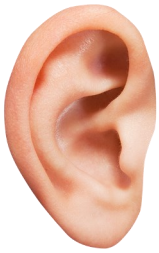
How I communicate

How I show pain and being unhappy

Where I live and who supports me



Health issues



Can I hear well

Can I see well

Can I move well

Do I use a wheelchair

Do I use a hoist

Eating and Drinking

Do I have diabetes

Do I have a wheat allergy

Do I need to eat gluten free

Do I need soft or blended foods

Can I choke on food or drink

What foods do I like

What foods do I **not** like

What else you need to know about me

My likes

My dislikes

Anything else you need to know about me