Panama Hospice & Respite

"Focusing on Quality of Life"

IN CASE OF EMERGENCY (ICE)
Information Sheet
CALL 911

CONTACT INFORMATION

First Name _____ **Last Name** _____

Address _____ **Apartment** _____

City _____ **Province/State** _____

Main Phone _____ **Alternate Phone** _____

Passport/Cédula _____ **Birth Date** _____ /_____ /_____

Helpline Member: **O yes** **O no** **D** **M** **Y**

Primary Language _____ **Gender** _____

O Advanced Care Directives **On File with** _____

EMERGENCY CONTACTS

Emergency Contact 1 _____

Main Phone _____ **Alt. Phone** _____

Emergency Contact 2 _____

Main Phone _____ **Alt. Phone** _____

RELEVANT MEDICAL HISTORY

O Cardiac (angina, heart attack, pacemaker) **O Diabetic (insulin, non insulin depend.)** **O Cancer**

O Stroke **O Alzheimer´s** **O Hypertension** **O Seizures** **O Dementias** **O Asthma**

O Congestive Heart Failure **O Psychiatric** **O COPD** **OTHER** _____

ALLERGIES

O No Known Allergies **O Penicillin** **O Aspirin** **O Sulpha** **O Codeine**

Others _____

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MEDICATION

1. _____	**5.** _____	**9.** _____
2. _____	**6.** _____	**10.** _____
3. _____	**7.** _____	**11.** _____
4. _____	**8.** _____	**12.** _____

MOBILITY/SENSORY

O Bedridden **O Dentures** **O Visual (blind/impairment/glasses/contacts)** **O Hearing (deaf/impairment/aid)**

O Mobility Issues (cane/wheelchair/walker/scooter/prosthetic limb)

O Patient needs assistance with walking, bathing, eating, toilet use

SPECIAL CONSIDERATIONS

Communicable disease _____

Other _____

Hospital Affiliation _____ **Doctor** _____

Insurance _____

SPECIAL DEVICES

O Feeding tubes **O Urinary catheters** **O Use of oxygen at home** **O Tracheostomy tube** **O Gastrostomy tube**

O Colostomy bag **Other** _____

PET CARE CONTACTS

Type of pets and names _____

Contact 1 _____ **Phone** _____

Contact 2 _____ **Phone** _____