Nananom Assisted Living
210 E. Hunter Dr. Globe, AZ 85501

EMERGENCY RESPONDERS' FORM

Resident's Name: _____ DOB: _____

List of known allergies to any medications, additives, preservatives, or materials like latex or adhesive.
_____

Diagnosis: _____

Resident's current mental/physical conditions or any episode/s:
_____
_____

An assisted living center or assisted living home that contacts an emergency responder on behalf of a resident shall provide to the emergency responder a written document that includes all of the following:

Emergency Remarks:

1. **Reason why emergency responder was requested**: _____
   _____
2. **List of all resident's medications** (including over the counter)

Medications	dosage	frequency

Note: Additional medication list can be added in a separate document.

3. **Pharmacy name**: _____Phone: _____ Email: _____
   Address: _____
4. **PCP Name:** _____ Phone: _____ Email: _____
5. **POA or Resident Representative/s:**
   Name: _____ Phone: _____
   Name: _____ Phone: _____
6. **Point of contact for the Facility: (Available anytime)**
   Name: _____ Position: _____ Phone: _____
   Name: _____ Position: _____ Phone: _____
   Name: _____ Position: _____ Phone: _____

Point of Contact for Coordination of Communication

Health Insurance: _____

Medicare number: _____ Medicaid # _____

1st Emergency contact: _____ Relationship: _____

Address: _____ Phone #: _____

2nd Emergency contact: _____ Relationship: _____

Address: _____ Phone #: _____

Representative or POA: _____ Phone #: _____

Fiduciary/Guardian: _____ Phone #: _____

Case Manager (if applicable): _____ Phone #: _____

Primary Care Provider: _____ Phone #: _____

Home health: _____ Phone #: _____

Hospice: _____ Phone #: _____

Therapist: _____ Phone #: _____

Family Member: _____ Phone #: _____

Other: _____ Phone #: _____

Other: _____ Phone #: _____

7. **Copy of Resident's Advance Directives:**
   ___ on file ___ Not available Other: _____

8. **Resident Transported to hospital:** ___ called 911 ___ Private vehicle other: _____
   a. ___ Representative was notified Time ____ am/pm Date: _____
   b. Name and location of the hospital**:** _____

9. **Discharge Plan: (to be followed up 48 hrs. after discharge)**
   a. **Name of Hospital: _____**
   b. **Phone: _____ Email: _____**
   c. **Contact Person: _____ Phone: _____**

   Notes: _____
   _____

10. **Discharge Evaluation and Assessment:**
    a. ___ pressure ulcers yes no if yes: location on the body: _____ Stage: ____
    b. Cognitive or impairments: _____
    c. Physical conditions: _____
    d. Patient's weight-bearing status: _____
    e. Diet: _____
    f. Does resident requires continuous medical services, intermittent nursing services or restraint? _____
    g. Does resident requires medical equipment or special device/s? _____
    h. Any new Doctor's order prescriptions? _____
    i. Does resident requires any follow up or recommended services? _____
    _____

11. **Discharged Documents signed by PCP?** Yes No

12. **Name of facility** that resident is being discharge: _____
    Location: _____ Contact person: _____

    Other Location (if any) _____

13. **Facility Resident Screening: Review and Discussion**
    _____
    _____

    ___ Resident is ok to re admit to the facility
    ___ Resident cannot accept the patient back to the facility
    Reason: _____
    _____

14. **Follow up care by the Hospital:** Date: _____ Time_____
    a. Name of person made the follow up: _____Phone: _____
    b. Notes or recommendation: _____
    _____
    _____
    _____

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Resident Medical Record Release Form

Authorization to Release Resident's Medical Information

Facility: _____
Address: _____
Phone: _____ Fax _____
Email Address: _____

Resident's Name: _____ Date: _____

Dear _____,

I hereby authorize and request to release and deliver to the above facility name all medical records, charts, files, progress notes, reports, service plans and other such information relative to the treatment provided to the resident name mentioned while under your care and all to the extent said information is available and within your possession.

You are further requested not to disclose any information concerning the resident's past/present medical condition or personal information to any other person without my express written permission.

Thank you for your cooperation,

Resident/Representative Signature: _____ Date: _____

Manager/Designee Signature: _____ Date: _____