Agency: **MEDICAL EMERGENCY RESPONSE PLAN**

Individual: **DOB:** **Initiation Date:**

Please see Prevention information which appears in the Health Care Plan.

Condition:

Description- If you see:

Emergency Instructions:

Condition:

Description- If you see:

Emergency Instructions:

Condition:

Description- If you see:

Emergency Instructions:

Emergency Contacts:

Name: **Relationship:** **Number:** **Preferred Urgent Care:**

Name: **Relationship:** **Number:** **Preferred Hospital:**

Name: **Relationship:** **Number:**

Name: **Relationship:** **Number:**

DNR/Advance Directives: Yes ☐ *Location:* **No** ☐

Nurse Signature: Review Date: