**Agency:** **MEDICAL EMERGENCY RESPONSE PLAN**

| **Individual:** **DOB:** **Initiation Date:** |
|---|
| *Please see Prevention information which appears in the Health Care Plan.* |

| | |
|---|---|
| **Condition:**<br>**Description- If you see:** | **Emergency Instructions:** |
| **Condition:**<br>**Description- If you see:** | **Emergency Instructions:** |
| **Condition:**<br>**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: