PORTABLE MEDICAL SUMMARY (Adapted from HRTW National Center form)

NAME: Address:		Home Phone: Alternate Phone: Email:	
Date of Birth:	**SS#:**		**DNR Signed: N/Y Date Signed:**
Age:	**Height:**	**Weight:**	**Blood Type:**
Supports Needed:			
Communication Preferences:			
Legal Decision Maker: __Self __Guardian (If Guardian, Guardianship: __ Limited __ Full) Guardian Name: Guardian Phone: Guardian Address:			

Diagnoses (include ICD-9 codes if known)	**Allergies (N/Y – If Yes, list below)**
Special notes:	

DOCTORS		**HOSPITAL**	
Name:	Specialty:		
MEDICATIONS (List name of medication, condition being treated, dosage and how often taken)		**IMMUNIZATIONS**	
Name / Condition / Dosage / Time		Type	Date
PRIMARY INSURANCE COMPANY INFORMATION Name of Company: *Subscriber:* Plan Code #: Subscriber #: Customer service: Case Manager:		**OTHER INSURANCE COMPANY INFORMATION** Name of Company: *Subscriber:* Plan Code #: Subscriber #: Customer service: Case Manager:	

Additional contact information

Residential Provider	Name:	Phone:
Case Manager	Name:	Phone:
Pharmacy	Name:	Phone:
Dentist	Name:	Phone:
Legal Health Surrogate	Name:	Phone:
In case of emergency, please contact	Name:	Phone: