Emergency Communication 4 ALL ....Letter/Word Communication Aid

FREE SPACE *(for your custom message)*

MY NAME IS...

I can't speak but I can hear and understand you.

WAIT. Please be patient.

Ask me questions if you need to, but please wait patiently for my replies.

I will point to where I hurt.

My vital information is on the back of this page.

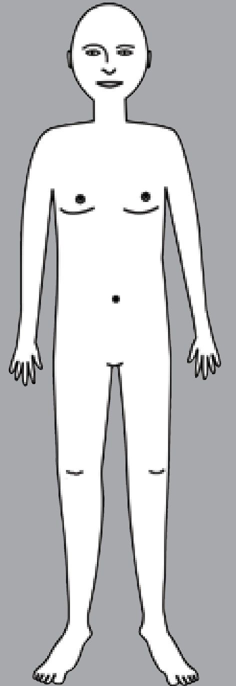
My technology needs to be charged.

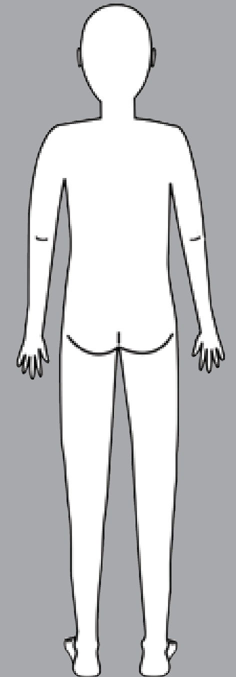
Please contact my family.

A	B	C	D	E
F	G	H	I	J
K	L	M	N	O
P	Q	R	S	T
U	V	W	X	Y
Z	?	.	!!	SPACE

Oops!	Help
Bathroom	Hungry
Afraid	Sick
I need/ want	I can't

0	1	2	3
4	5	6	7
YES	8	9	NO





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PERSONAL INFORMATION

1. NAME ______________________

DOB ______________________

Address ______________________

Cell Phone ______________________

Home Phone ______________________

Email ______________________

2. EMERGENCY CONTACT

Name ______________________

Address ______________________

Cell Phone ______________________

Home Phone ______________________

Relation ______________________

3. 2ND EMERGENCY CONTACT

Name ______________________

Address ______________________

Cell Phone ______________________

Home Phone ______________________

Relation ______________________

4. DOCTOR

Name ______________________

Address ______________________

Phone ______________________

5. HEALTH INSURANCE

❑Private ❑Medicare ❑Medicaid ❑Other ________

Policy Number ______________________

Date Issued ______________________

6. PRESCRIPTION MEDICATIONS

Name & Dosage ______________________

Name & Dosage ______________________

Name & Dosage ______________________

Name & Dosage ______________________

Name & Dosage ______________________

7. OVER THE COUNTER DRUGS

1) ______________________

2) ______________________

8. PHARMACY NAME ______________________

Contact Person ______________________

Phone ______________________

9. ALLERGIES [complete list] ______________________

____

____

10. RELEVANT MEDICAL HISTORY [brief] ______________________

____

____

____

____

11. SUPPORT AGENCY [if applicable] ______________________

____

____

12. MEDICAL EQUIPMENT/TECHNOLOGY SUPPLIER

____

____

13. EQUIPMENT/SUPPORT NEEDED FOR INDEPENDENCE

Personal Assistance Services

Name ______________________

Phone ______________________

Allotted Hours ______________________

Mobility/Transferring ______________________

____

Communication ______________________

____

Hygiene/Toileting /Vision ______________________

____

Telephone Use ______________________

____

Finances/Writing ______________________

____

Cooking ______________________

____

Eating and Diet ______________________

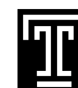
____

Transportation ______________________

____

Service Animals ______________________

____



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