HOUSTON Methodist
TEXAS MEDICAL CENTER

WHAT MATTERS

In Case of Emergency

In the event of an emergency the enclosed information will be beneficial to you and your healthcare providers as you transition through the hospital's care services. It is also recommended that you take these forms to your regular scheduled doctor's appointment.

Please fill out the enclosed information sheets and add the "Suggested Items" to this packet. It is important to update the information frequently to have the correct medications and contact information. The magnet on the folder may be helpful to keep the folder handy on your refrigerator.

Suggested Items

- **Copy of insurance card(s) – Front and back**
- **Copy of Identification Card (Driver's License)**
- **Copy of Advance Directive, Living will or Out of Hospital DNR**
- **Enclosed (Pg2)- Medical Care Form, complete with input of your physician**
- **Enclosed (Pg3-4)- Medication Lists filled out with your current medications (remember to keep updated as medications change)**
- **Enclosed (Pg5)- List of emergency contact numbers and Hospital of choice form**

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Medical Care Sheet

Name of Physician:_____

Telephone number:_____

Allergies:_____

List of Medical Issues:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Please list any physicians you may visit in addition to you Primary Care Physician.

Name of Physician:_____

Telephone number:_____

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Telephone number:_____

Name of Physician:_____

Telephone number:_____

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Medication List

Name:_____

DATE:_____

Please write all of your current medication, including vitamins and over the counter pills, in the table below. Sometimes people get sick without warning and must call for help when they are alone. Having a current medication list will help medical providers take better care of you in the event of an emergency.

(Please make copies of this blank form to update when your medications change.)

Name of Pharmacy:

_____

Pharmacy telephone number: _____

Name of Medication	Dose of Medication	Time and Frequency	I stopped taking this medication because:	Last time I took this medication

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_____

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Patient Information

Name:_____

Address:_____City:_____

State:_____ Zip:_____ Phone:_____

Email Address:_____

Emergency Contact

Name:_____Relation:_____

Address:_____City:_____

State:_____ Zip:_____

Phone:_____

EmailAddress:_____

Hospital of Choice

Name of Hospital:_____

Address:_____City:_____

State:_____ Zip:_____

Phone:_____

Email Address:_____

Primary Care Provider

Name of Physician:_____

Name of Practice:_____

Address:_____City:_____

State:_____ Zip:_____ Phone:_____

Email

Address:_____