**NAME:**

**DATE:**

**PHYSICIAN(S) NAME AND PHONE NUMBER**
1.  
2.  
3.  

**CONTACT(S) NAME AND PHONE NUMBER**
1.  
2.  
3.  

**SIGNIFICANT SURGERY**

**LOCATION OF ADVANCE DIRECTIVES (if applicable)**

_DNR & POLST require additional forms. Check which form(s) you have_

- [ ] DNR - Do Not Resuscitate
- [ ] POLST - Physician’s Orders for Life-Sustaining Treatment

Please list location of DNR and POLST forms in box below:

**MEDICAL CONDITIONS** (Check all that apply and list other conditions. Provide additional information below)

- [ ] No medical conditions
- [ ] Stroke
- [ ] Asthma / COPD
- [ ] Seizure Disorder
- [ ] Bleeding Disorder
- [ ] Diabetes / Insulin Dependent
- [ ] Heart Problems
- [ ] Hypertension

**SEVERE ALLERGIES & DRUG REACTIONS** (List any severe allergies and/or drug reactions below)

- [ ] No known allergies or reactions

Please provide more details on medical conditions listed above and/or other information emergency responders should know:

**HOSPITAL PREFERENCE**

You might be transported to a different hospital based on your condition and/or hospital status.
MEDICAL EMERGENCY INFORMATION

Spokane
FIRE DEPARTMENT®