Vial of Life

Patient Information Card

Patient Information		
Last Name:	**First Name:**	**Initial:**
Date of Birth (yyyy-mm-dd)	**Health Card Number**	**Gender** Male ☐ Female ☐
Address	**City**	**Postal Code**
Home Phone	**Cell Phone**	

Primary Care Provider	**Phone**	**Location**

Personal Support Information					
None ☐	Spouse ☐	Caregiver ☐	Parent ☐	Child ☐	Other ☐
(If Other Provide details)					

Emergency Contact Information	
Name:	**Relationship**
Primary Contact Number	**Secondary Contact Number**

Resuscitation Status	
The patient wishes to have everything possible done in the event that their heart stops beating or they stop breathing ☐	The patient does not wish to have any measures performed in the event that their heart stops beating or they stop breathing ☐
These wishes have been discussed with those individuals who are close with the patient ☐	The patient has a valid DNR and a copy will be placed with the Vial of Life Patient Information Card. ☐

Medical History			
Cardiac	**Respiratory**	**Neurological**	**Cancer**
Heart Failure ☐	COPD ☐	Strokes ☐	Yes ☐
MI ☐	Asthma ☐	TIA's ☐	No ☐
Angina ☐	Emphysema ☐	Seizures ☐	Treatment ☐
Pacemaker ☐	Bronchitis ☐	Surgery ☐	Chemo ☐
Irregular Heart Beat ☐	Pneumonia ☐	Syncope ☐	Radiation ☐
Hypertension ☐	Tuberculosis ☐	Tumors ☐	Stage
High cholesterol ☐	Fluid on Lungs ☐		
Abdominal	**Diabetes**	**Mental Health**	**Blood Disorders**
Ulcers ☐	Type I ☐	Schizophrenia ☐	Hepatitis ☐
Rectal Bleeding ☐	Type II ☐	Depression ☐	HIV/AIDS ☐
Bowel Troubles ☐	Controlled	Bipolar Disorder ☐	Hemophilia ☐
Kidney Disorders ☐	Yes ☐	ADD/ADHD ☐	Blood Clots ☐
GERD ☐	No ☐	PTSD ☐	Anemia ☐

Social History		
Smoker ☐	Quit (what year)	Packs/day
Alcohol Consumption ☐	Quit (what year)	Drinks/week
Recreational Drug Use ☐	Quit (what year)	What/How often

Additional Medical Profile Information

Allergies				NKA ☐
ASA ☐	Penicillin ☐	Codeine ☐	Sulpha ☐	
Other ☐				

In an Emergency call 9-1-1

Vial of Life

Patient Information Card

Medications

(Current Pharmacy Print Out Preferred)

Medication	Dosage	Frequency	Medication	Dosage	Frequency

I am connected with the following organizations/support services:			
Health Links Client ☐			
CCAC	☐	Respiratory Therapy	☐
CMHA	☐	Telehomecare	☐
Diabetes Clinic	☐	TeleCheck	☐
Alzheimer's Society	☐	Occupational Therapy	☐
Dufferin County Community Paramedic	☐	Dufferin County Community Support Services	☐
Hospice	☐	Caledon Community Support Services	☐
Caledon Meals on Wheels	☐		
Other (Please List)			

Please place the completed Patient Information Card inside the medication vial on the upper right hand shelf of the refrigerator door. The personal information will provide all the information required by the Paramedics, Nurses & Physicians in the event of an emergency.

Please attach the Med Check from your local pharmacy if available

It is VITAL that you keep your INFORMATION CARD UP TO DATE.

In an Emergency call 9-1-1