Resident Pre-Emergency Documentation

Facility Name: Lavender Hills Assisted Living	**Facility phone No:**	
Resident Name:	Age:	DOB:
Responsible Person:	Home Phone:	Cell Phone:
Additional Family:	Home Phone:	Cell Phone:
Physician:	Phone Number:	
Religious Preference:	Funeral Home Preference:	
Current Diagnosis:		
Allergies:		
Current Pharmacy:		

Current Health Conditions/ Past Surgeries

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DNR Or Resuscitate

Hospital of Choice: _____