

NEED TO KNOW

Name:	Age:	Birthday:
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CURRENT HEALTH ISSUES

Describe:	Medications:
Allergies:	

COMMUNICATION

My native language is...	<input type="checkbox"/> English	<input type="checkbox"/> Spanish	<input type="checkbox"/> other:
I understand...	<input type="checkbox"/> everything	<input type="checkbox"/> some things	<input type="checkbox"/> very little
I express myself with...	<input type="checkbox"/> verbal speech	<input type="checkbox"/> pencil and paper	<input type="checkbox"/> speech device
	<input type="checkbox"/> gestures	<input type="checkbox"/> American Sign (ASL)	<input type="checkbox"/> other:
I can answer...	<input type="checkbox"/> yes/no questions	<input type="checkbox"/> simple questions (who, what, where)	<input type="checkbox"/> complex questions (why, how, when)
I can read...	<input type="checkbox"/> basic words	<input type="checkbox"/> sentences	<input type="checkbox"/> I need you to read to me.
I can write...	<input type="checkbox"/> basic words	<input type="checkbox"/> sentences	<input type="checkbox"/> I need you to write for me.

LIFESTYLE

Family:	Occupation / Work:
Hobbies:	Religion:

LIMITATIONS (describe)

<input type="checkbox"/> vision loss	<input type="checkbox"/> hearing loss	<input type="checkbox"/> mobility issues	<input type="checkbox"/> cognitive issues	<input type="checkbox"/> other
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EMERGENCY CONTACT

Name	Relationship	Phone Number

OTHER IMPORTANT PEOPLE

Name	Relationship	Phone Number

PLANNING

I have a:	<input type="checkbox"/> Living Will	<input type="checkbox"/> Do Not Resuscitate	<input type="checkbox"/> Healthcare Proxy
Documents are located at:			

INSURANCE

Primary	Secondary
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OTHER INFORMATION

Favorite foods	
Favorite music	
Favorite TV shows	
Nickname	Pronoun
Additional Information <i>(Include anything this person needs to be comfortable – any assistive technology - any specific information not already on this document.)</i>	