CMC
CATHOLIC MEDICAL CENTER

Divine Mercy
Parish Nurse Program

VIAL OF LIFE

Please fill out this Medical Data Form and insert it into the plastic vial; then place the vial in the door of the refrigerator. If any information changes at any time, please make corrections.

Name_____ Date form completed _____

Address_____ Telephone number_____

_____ Date of birth _____

Emergency Contact _____ Medicare # _____

Phone _____Relationship _____ Health care plan _____

Doctor's Name _____ Policy # _____

Doctor's Phone _____ Religion _____

Hospital preference _____ Clergy-Name _____ Phone _____

HEALTH INFORMATION

Allergies_____

Major illnesses/past medical history/recent hospitalizations_____

_____

_____

_____

_____

Are you hard of hearing or deaf ? □ Yes □ No Do you wear hearing aids? □ Yes □ No

If yes : □ Left □ Right

Do you wear dentures? □ Yes □ No **If yes**: □ Upper □ Lower

Do you wear glasses? □ Yes □ No

Do you have vision problems? _____

List of Medications- Include over the counter medications, supplements, vitamins, medication patches:

Feel free to attach list

	Name of medication	Dosage	How often taken	Where to locate
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

Pace maker Model # _____ Defibrillator Model # _____

Blood type _____ Have you signed an organ donor card? □ Yes □ No

Do you have a Living Will? □ Yes □No (if Yes, attach a copy to this form)

Do you have a power of attorney for health care? □ Yes □ No

Do you have a Do Not Resuscitate Order from your Doctor? □ Yes □ No

Please add any information you may find helpful in an emergency:

_____

_____

_____

_____

_____