

ADVANCE DIRECTIVES

NON-HOSPITAL DO NOT RESUSCITATE HEALTH CARE PROXY (attach originals)
 NO YES NO YES

Emergency Contact - Can provide emergency housing? () Yes () No	
NAME (First, M.I., Last)	PHONE NUMBER
ADDRESS (Street, Apt./City/Zip Code)	
Emergency Contact - Can provide emergency housing? () Yes () No	
NAME/TITLE	PHONE NUMBER
ADDRESS # (Street, Apt./City/Zip Code)	

MEDICAL HISTORY

- | | |
|---|---|
| <input type="checkbox"/> Bleeding Problems | <input type="checkbox"/> Contacts |
| <input type="checkbox"/> Breathing Problems | <input type="checkbox"/> Dentures |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Glasses |
| <input type="checkbox"/> Diabetic | <input type="checkbox"/> Hearing Aid |
| <input type="checkbox"/> Dialysis | <input type="checkbox"/> Isolation |
| <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Lifeline |
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Oxygen Dependent |
| <input type="checkbox"/> Memory Loss | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> MRSA | <input type="checkbox"/> Prosthesis |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Walker |
| <input type="checkbox"/> Sight Problems | <input type="checkbox"/> Wheelchair |
| <input type="checkbox"/> VRE | |

VACCINES

PNEUMOVAX DATE:	INFLUENZA DATE:
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COMMUNITY AGENCIES:

- | | | | |
|------------------------------|-------------------------------|-------------------------------|---|
| <input type="checkbox"/> DSS | <input type="checkbox"/> NCHS | <input type="checkbox"/> OFA | <input type="checkbox"/> DOH |
| <input type="checkbox"/> MOW | <input type="checkbox"/> JCEO | <input type="checkbox"/> DDSO | <input type="checkbox"/> Catholic Charities |

Case Worker: _____ Phone: _____

Consumer Directed

**PLEASE PLACE THIS ON THE
FRONT OF YOUR REFRIGERATOR**

VITAL LINK

Information between you and
your doctor

Please call if you need assistance with this form.



(518) 565-4902

www.clintoncountynyconnects.org

Please bring this packet with you **WHENEVER** you visit your doctor, the hospital, the emergency room, a health care provider or temporary shelter and ask them to help you keep it updated.

Additional items to be taken if you must leave your home in an emergency: medicines, medical equipment and supplies, such as oxygen. Make arrangements for your pets.

NAME (First, M.I., Last)	Date Completed/Revised
DOCTOR'S NAME	PHONE NUMBER
PHARMACY NAME	
LOCAL	
MAIL ORDER	

