Tate Behavioral

Autism Services, Assessment, Consultation, and Training

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Individualized Emergency Health Care Plan

Client's Name: _____ Today's Date: _____

Nickname: _____		Date of Birth: _____
Primary Language of Communication: _____		
Home Address: _____		
Secondary Address: _____		
Parent/Caregiver: _____	Relationship: _____	Phone: _____
Parent/Caregiver: _____	Relationship: _____	Phone: _____
Emergency Contact: _____	Relationship: _____	Phone: _____
Emergency Contact: _____	Relationship: _____	Phone: _____
Diagnosis:		
Allergies or Dietary Restrictions:		

Relevant Health History: (recent surgery, current status)

Medications	Dose/Time	Known Side effects

Medical Records on file at: _____
Phone: _____
Fax: _____

Hospital Information		
Preferred Hospital: _____ _____	Address: _____ _____	Phone:_____ ED Phone: _____
Secondary Hospital: _____ _____	Address: _____ _____	Phone:_____ ED Phone: _____
Physician Information		
Doctor to call in an Emergency: _____	Phone: _____	Fax: _____
Primary Care Physician: _____	Phone: _____	Fax: _____
Specialist: _____	Phone: _____	Fax: _____
Specialist: _____	Phone: _____	Fax: _____

Specialist: _____	Phone: _____	Fax: _____
Preferred Pharmacy		
Name: _____ _____	Address: _____ _____	Phone: _____ Fax: _____
Insurance Information		
Insurance Provider: _____	ID #: _____	Phone: _____
Important Baseline Health Information: (vitals, neurological, cognitive function, etc.)		
Equipment and assistive technology: (braces/orthotics, walker, wheel chair, communication devices, insulin pump, etc.)		
Most important things to know about this client in an emergency: (fears, behaviors, etc.)		
Things that calm this client when scared or in pain: (distractions, toys, books, songs, breathing exercises, etc.)		
Recent Photo of Client:		Date of photo: