FACT SHEET

Client

Name:		Hospital of Choice:	
Address		home phone	
		cell phone	
		other phone?	

birthdate	religion	Social Security #	legal competency status:

Contact Person

Name:		cell phone	work phone
		email	

Insurance Information

medicaid #		medicare #		other insurance?

Guardian / emergency contact / other

Name:		address		other phone?

cell phone	work phone	email

other emergency contact name:	relationship	cell	other phone?
other / next of kin	relationship	cell	other phone?

Other information

Physician		phone	address
dentist		phone	address

service coordinator		direct line:	Gateways Community Services Region VI

Physical disability / medical diagnosis / other issues

Special diet / hygiene concerns

Allergies

Communication

Supervision

Medications

Medication	Frequency / Dose	Reason

Immunizations

Immunizations			
		Date of Last Tetnus	

Allergies	

Physical Appearance

Sex		Weight	
Race		Eyes	
Height		Hair	
Distinguishing Marks			

Date Form Completed		Completed by	

Review