I AM A NEW PATIENT AT THIS HOSPITAL. THESE ARE MY MEDICAL REQUESTS AND AUTHORIZATIONS FOR MY CARE TEAM

Name: _____ Best Phone Number: _____
Alternative Number: _____
Age and Birthdate: _____ Social Security No.: _____

Home Address:_____ My email address: _____
_____

My Insurance Provider: _____ Group Number: _____
I am the primary person on insurance: Yes/No Individual Number:_____
IF NO, who is the primary holder: _____

I authorize you to share medical information or communicate with someone I know.
PLEASE SEE ATTACHED CONSENT INFORMATION ON PAGE 2
If yes, name and relationship: _____
How do we contact them?: _____

I think I have COVID-19/CORONAVIRUS: YES / NO

My Symptoms: _____
What date did they start?: _____

MEDICAL HISTORY

My Medical Conditions (especially respiratory): _____
_____

My Medications: _____
_____
_____

My Allergies:_____
_____

I have been Hospitalized before for: _____

MY REQUESTS FOR MY CARE

I have Advance Directives (such as a durable power of attorney for healthcare and living wills):
1. YES. It is attached to this form. 2. NO. I would like help with one. 3. NO. I do not need it.

I would like hospital or medical staff to contact the person named above with updates about my care and condition. While I am ill, I would like information about my care in writing, provided to me and my emergency contact at the above email addresses, to the extent it can be provided without disrupting the care of other patients.

Consent to Treatment. I consent to the procedures which may be performed during this hospitalization or during an outpatient episode of care, including, but not limited to, emergency treatment or services, and which may include laboratory procedures, x-ray examination, diagnostic procedures, medical, nursing or surgical treatment or procedures, anesthesia, or hospital services rendered as ordered by the Healthcare Provider. I consent to allow nurses, medical students as part of their training in health care education, and other qualified emergency individuals to participate in the delivery of my medical care and treatment or be observers while I receive medical care and treatment at the Hospital, under supervision of hospital staff.

Communications About My Healthcare. I authorize my healthcare information to be disclosed for purposes of communicating results, findings, and care decisions to my family members and others I designate to be responsible for my care. If I am able, I will provide those individuals with a password or other verification means specified by the hospital. If I am not able to communicate due to illness or treatment, I request that a healthcare provider communicate with the person listed on page 1, and accept this form as my authorization to disclose medical information related to my treatment of any condition for which I am hospitalized.

Consent to Medication Not Yet FDA Approved and/or Medication Prepared/Repackaged by Outsourcing or Compounding Pharmacy. As part of the services provided, I acknowledge that I may be treated with a medication that has not received FDA approval. I may also receive a medication that has been prepared or repackaged by an outsourcing facility or compounding pharmacy. Certain medications, for which there are no alternatives or which my physician recommends, may be necessary for potentially life-saving treatment. I consent to receive such treatment which, in the profession judgment of my care team, is necessary for my condition, if I am unable to communicate otherwise.

IN WITNESS WHEREOF, I have executed this directive, as my free and voluntary act and deed, this ___ day of _____, 2020.

_____

WITNESS: _____

PLEASE SEE ATTACHED FORMS:

ADVANCED MEDICAL DIRECTIVE

DNR FORM

LIVING WILL

_____