Special Considerations Information

Name _____

Address _____ Phone _____

Personal Support Name _____

Address _____ Phone _____

1 ALLERGIES

Allergy	Severity	Usual Treatment & Medications

2 MEDICATIONS - PROFILE OF MEDICAL NEEDS

Diagnosis	Medication Name	Dosage	Directions	Special Care	Extra Items (e.g. syringes)

3 ASSISTIVE EQUIPMENT AND MEDICAL SUPPLIES

Type	Where Located	Alternative Equipment	Extra Items (i.e. batteries)	Special Instructions

4 NAMES AND NUMBERS OF IMPORTANT CONTACTS

Contact	Name	Telephone #
Family physician		
Specialists		
Pharmacist		
Building manager		
Church leader, counsellor		
Home care/personal attendant		
Local family/emergency contact(s)		
Out-of-area emergency contact		
Transportation provider		
Other important service provider		

5 DOCUMENTS AND IMPORTANT PEOPLE TO CONTACT

I have made copies of the following:

- ☐ ID (Passport, Driver's Licence, Care Card, etc.)
- ☐ Legal and other documents (Will, Advance Directive, Home Insurance, etc.)