EMERGENCY CONTACT INFORMATION FORM

Practical Choices and Healthy Change Therapy, LLC

Client Name: ______________________________ **Date:** ____________________

Person to be contacted in an Emergency: ______________________________

Address of Emergency Contact: ______________________________

Phone Number of Emergency Contact: ____________________ **Relationship to you:** ______________

General Health Condition: ______________________________

Significant Medical/Health Problems/Conditions: ______________________________

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Known Allergies: ______________________________

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Medications That You Take on a Regular Basis:

Name of medication: ______________________________

Dose: ________________ Times per day for each medication: ____________________

Name of medication: ______________________________

Dose: ________________ Times per day for each medication: ____________________

Name of medication: ______________________________

Dose: ________________ Times per day for each medication: ____________________

Name of medication: ______________________________

Dose: ________________ Times per day for each medication: ____________________

Name of Primary Care Physician: ______________________________

Address of Physician: ______________________________

Physician's Phone Number: ______________________________

Client's Signature: ______________________________

Note:

* The information requested on this form will be disclosed only to emergency medical personnel in the event that you are involved in an accident or experience a medical crisis while under my care that requires emergency medical care;

* You have the right to refuse to provide information requested on this form. In the event that you do not wish to disclose this information, please write "Refused to Provide" across the face of the form, sign the form and return it to your therapist.

*Your medical information will not be released to any other person, entity or organization and will be afforded strict protection against loss, compromise or unauthorized disclosure.