Shepherd Home Health Care, Inc.
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EMERGENCY PLAN

If any life-threatening situation should occur, and you need
an ambulance, the police, or fire department...

CALL 911 IMMEDIATELY!

Please keep this information where it may be easily retrieved.

PATIENT: _____ PHONE: _____

2ND PATIENT IDENTIFIER ID / MEDICARE #:_____ DOB: _____

EMERGENCY CONTACT: _____ PHONE: _____

PATIENT CAREGIVER/IHHS: _____

NUMBER OF HOURS: _____ PHONE: _____

MD: _____ PHONE: _____

ALLERGIES: _____

PHARMACY: _____ PHONE: _____

HOSPITAL OF CHOICE: _____ PHONE: _____

DME SUPPLY COMPANY: _____ PHONE: _____

ADULT DAY CARE: _____ DAYS: _____ PHONE: _____

DIALYSIS CENTER: _____ DAYS: _____ PHONE: _____

OUTPATIENT REHAB: _____ DAYS: _____ PHONE: _____

ACUITY LEVEL: LOW _____ MEDIUM _____ HIGH _____

ADVANCE DIRECTIVES: Does the patient have an Advance Directives? ☐ Yes ☐ No

If yes, please attach a copy of the Advance Directives to this Emergency Plan.

Emergency conditions to report to 911:

1. Severe shortness of breath.
2. New onset of chest pain, jaw pain, arm pain or feeling of indigestion accompanied by sweating and/or nausea.
3. Uncontrollable active bleeding.
4. Sudden change in mental status or loss of consciousness.
5._____

Conditions to be reported to your home health nurse and physician:

1. Temperature above 101 degrees for more than 24 hours.
2. Pain not relieved by medication already ordered by Physician.
3. Nausea and vomiting.
4. Dizziness, weakness, and/or faintness.
5. 1f applicable-Changes in drainage, color, odor, size of wound(s)
6._____