

St. John's Adult Day Program Authorization for Emergency Treatment

In the event the situation arises, I (the family caregiver or responsible party) authorize and give full consent to St. John's to obtain emergency medical treatment and to carry out whatever treatment is needed. I agree to accept financial responsibility for the cost of any emergency medical treatment rendered.

I understand that St. John's will follow the procedure listed below if emergency medical treatment is deemed necessary by program staff.

- A. Dial 911 to obtain emergency medical assistance and transportation to the nearest hospital (Anderson Hospital, Maryville).
- B. Call the primary caregiver designated below. If this individual cannot be reached, staff will attempt to reach alternate emergency contacts listed below.
- C. If an emergency contact person cannot be reached, a staff member or volunteer from the program will accompany the participant to the hospital and will remain there until a family caregiver or other responsible person arrives.
- D. If the family has provided the program with a written copy of a living will or "Do Not Resuscitate" order, a copy will be given to the emergency medical personnel. (Copy Provided? Yes No) **CPR: YES NO DNR: YES NO** Initial: _____

Clients Name: _____ Birth Date: _____

Address: _____ City, State, Zip: _____

Family/Guardian client lives with: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Caregiver's Employer: _____

IF YOUR MAIN WORK NUMBER DEFERS TO VOICE MAIL, PLEASE LIST AN ALTERNATIVE NUMBER. If family/guardian cannot be reached St. John's will contact one of the following people on your list. (PLEASE DO NOT LIST VOICE MAIL)

Name: _____ Relationship: _____

Day Phone: _____ Evening Phone: _____

Name: _____ Relationship: _____

Day Phone: _____ Evening Phone: _____

Days Attending: MON TUES WED THURS FRI Hospital Preference: _____

Primary Physician: _____ Phone: _____

Alternative Physician: _____ Phone: _____

Alternative Physician: _____ Phone: _____

Medicare Number: _____ Medicaid Number: _____

Primary Insurance Name: _____ Group/ID# _____

Supplemental Insurance Name: _____ Group/ID# _____

See Reverse for additional information

