

Lyme FAST Squad & LCC Parish Nurse – File of Life

One form per resident

Updated: ____/____/____

Name: _____ DOB: ____/____/____

Do you have a DNR? Y/N If yes, where can it be found?

Preferred Hospital: _____

MD: _____ Tel: _____

☐ Emergency Contact

☐ POA

Name: _____ Tel: _____

Medical Background

Drug Allergies: _____

Environmental Allergies: _____

Medical History: Check those that affect you & specify condition

Cardiac	Cancer	Kidney
Liver	Stroke	Memory
Pulmonary	Vision	Hearing
Diabetes	Urinary	Fatigue
Balance/walking	Pain	Emotional

Life-threatening issues: _____

Other: _____

Prescription medication/dose	AM dose	PM dose

For additional forms or assistance in completing this form, contact the LCC Parish Nurse -795-2850 or lymeparishnurse@gmail.com.

Additional Emergency Contacts:

1. Name	Tel#
Town/State	Relationship
2. Name	Tel#
3. Name	Tel#

Other people living in my home

1. Name	Relationship
<input type="checkbox"/> I care for him/her	<input type="checkbox"/> He/she cares for me <input type="checkbox"/> NA
2. Name	Relationship
<input type="checkbox"/> I care for him/her	<input type="checkbox"/> He/she cares for me <input type="checkbox"/> NA

Pharmacy	Town
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Names/phone # of people who help you

VNA/Caregiver_____

Pet care and types of pets_____

Housekeeping_____

Transportation_____

Personal care_____

Finances/bill paying_____

Shopping/errands_____

Prescription pick up_____

Overnight support_____

Spiritual comfort_____

Outdoor chores_____

Snow removal_____

Other_____