Forensic Consultation & Counseling Service, LLC
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. Email: Billing@fccsvt.com

. **EMERGENCY INFORMATION SHEET**

Client ID # _____Email : _____

Patient Name _____ DOB_____ Ph_____

Address, City, State, Zip: _____

Emergency Contact

Please list names of who we should contact in case of an emergency. List your first choice contact first, and a secondary contact in the event we cannot contact your first choice. Any prior information will be removed and the new information will be entered.

1. Name:_____ Relationship;_____

   Address: _____City: _____State: _____

   Zip Code: _____Home Phone: _____Work _____ Cell:_____

2. Name:_____Relationship:_____

   Address:_____ City:_____

   State:_____ Zip Code: _____ Contact Phone:_____

Medical Information

Please list the name and phone number of your doctor and any medications/conditions you feel we should know about.

Primary Care Physician Name:_____

Address, City, State, Zip:_____

Phone #: _____ Up to Date on Immunizations ☐ Yes ☐ No

Height_____ Weight _____

Relevant Medical Information

Please check off any of the following conditions if you are currently being treated for them.

☐ Diabetes ☐ Heart Condition ☐Mental Health _____
☐ High blood pressure ☐ Seizure disorder ☐ Other_____

Please list any prescribed medications, the prescribing doctor and their phone number.

Medication Doctor Phone #

_____

_____

Please tell us about anything else you think might be helpful in case of an emergency (allergies, disabilities, etc.).

_____

_____