Family Medical
Emergency Protocol

RETURN ON LIFE® WEALTH PARTNERS
Your Life. Your Money. Your Way.®
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Name_____ DOB_____ Blood Type_____ Last Updated_____
Address _____
Spouse Name_____

IN THE EVENT OF AN EMERGENCY DIAL 911

Police Department non-emergency phone # _____
Fire Department non-emergency phone # _____
Poison Control non-emergency phone # _____

HOSPITAL/EMERGENCY ROOM

Preferred hospital name/address/phone number_____
Emergency Room name/address/phone number_____
Urgent Care Facility name/address/phone number_____

MEDICAL INSURANCE INFORMATION

Member: Self ☐ Spouse ☐
Health Insurance Plan Name_____ Company Sponsor_____
Health Plan #_____Group ID # _____ Payer ID # _____
Member ID#_____ Medicare ID#_____
Claims Address_____
Phone Number _____ Website_____

PERSONAL INFORMATION

Allergies
Pre-existing Conditions / Prior Surgeries and Dates
Vaccines and Immunizations, including date of last Tetanus shot

Family Medical Emergency Protocol

MEDICATIONS / SUPPLEMENTS

Your Name _____

Prescriptions	Dosage / Frequency	Number of Years Taken	Purposes and Condition Treated
Over the Counter	**Dosage / Frequency**	**Number of Years Taken**	**Purposes and Condition Treated**
Supplements	**Dosage / Frequency**	**Number of Years Taken**	**Purposes and Condition Treated**

Family Medical Emergency Protocol

Your Name _____

PHYSICIAN / HEALTHCARE PROVIDERS

PRIMARY CARE PHYSICIAN

Practice name and address: _____

Doctor Name_____ Phone _____ After-Hours Phone_____

SPECIALIST 1

Practice name and address: _____

Doctor Name_____ Phone _____ After-Hours Phone_____

SPECIALIST 2

Practice name and address: _____

Doctor Name_____ Phone _____ After-Hours Phone_____

SPECIALIST 3

Practice name and address: _____

Doctor Name_____ Phone _____ After-Hours Phone_____

SPECIALIST 4

Practice name and address: _____

Doctor Name_____ Phone _____ After-Hours Phone_____

DENTIST

Practice name and address: _____

Doctor Name_____ Phone _____ After-Hours Phone_____

OPHTHALMOLOGIST

Practice name and address: _____

Doctor Name_____ Phone _____ After-Hours Phone_____

PEDIATRICIAN

Practice name and address: _____

Doctor Name_____ Phone _____ After-Hours Phone_____

VETERINARIAN

Practice name and address: _____

Doctor Name_____ Phone _____ After-Hours Phone_____

Family Medical Emergency Protocol

Your Name _____

EMERGENCY CONTACTS

Contact the following family members/friends/business associates in the event of an emergency or incapacitation:

PERSONAL

Name (1)_____ Relationship _____

Mobile Phone _____ Home Phone _____ Work/Alternate Phone _____

Name (2)_____ Relationship _____

Mobile Phone _____ Home Phone _____ Work/Alternate Phone _____

FINANCIAL ADVISOR

Contact_____ Phone_____ After-Hours Phone_____

Firm/Address _____

ATTORNEY

Contact_____ Phone_____ After-Hours Phone_____

Firm/Address _____

TAX ADVISOR/CPA

Contact_____ Phone_____ After-Hours Phone_____

Firm/Address _____

OTHER ADVISOR

Contact_____ Phone_____ After-Hours Phone_____

Firm/Address _____

BANK/FINANCIAL INSTITUTION (1)

Contact_____ Phone_____ After-Hours Phone_____

Institution/Address _____

BANK/FINANCIAL INSTITUTION (2)

Contact_____ Phone_____ After-Hours Phone_____

Institution/Address _____

BANK/FINANCIAL INSTITUTION (3)

Contact_____ Phone_____ After-Hours Phone_____

Institution/Address _____

Family Medical Emergency Protocol

Your Name _____

IMPORTANT DOCUMENTS

DOCUMENT ITEM	YES	NO	LOCATION
Healthcare Power of Attorney			
General Power of Attorney			
Living Will			
Trust			
Life Insurance Policy(s)			
Long-Term Care Policy(s)			
Disability Insurance Policy			
Safety Deposit Box			
Cemetery Interment Certificate			

Other Items of Importance:

Family Medical Emergency Protocol

Your Name _____

FUNERAL ARRANGEMENTS

Funeral home name/address/contact person: _____

_____

Type of service: cremation/burial/entombment _____

If Cemetery Interment, indicate cemetery name/address/ Plot Number: _____

_____

Other: Location where you want ashes spread or interred: _____

_____

SPECIAL INSTRUCTIONS