ADVANCE DIRECTIVES	
MOLST, POA, OR HEALTH CARE PROXY (attach originals) ☐ NO ☐ YES	NON-HOSPITAL DNR ☐ NO ☐ YES
POA or Proxy - Can provide emergency housing? ( ) Yes ( ) No	
NAME (First, M.I., Last)	Phone: (home, cell, office)
ADDRESS (Street, Apt./City/Zip Code)	
Other Emergency Contact - Can provide emergency housing? ( ) Yes ( ) No	
NAME (First, M.I., Last)	Phone: (home, cell, office)
ADDRESS (Street, Apt./City/Zip Code)	

Current Medical Issue or Problem

- ☐ Bleeding Problems
- ☐ Breathing Problems
- ☐ Cancer
- ☐ Depression/Anxiety
- ☐ Diabetic
- ☐ Dialysis
- ☐ Hearing Impairment
- ☐ High Blood Pressure
- ☐ Memory Loss
- ☐ MRSA/VRE/CDIF
- ☐ Seizures
- ☐ Visual Impairment
- ☐ Contacts
- ☐ Dentures
- ☐ Glasses
- ☐ Hearing Aid
- ☐ Lives Alone
- ☐ Lifeline
- ☐ Oxygen, CPAP, BIPAP
- ☐ Pacemaker/AICD
- ☐ Prosthesis
- ☐ Walker
- ☐ Wheelchair
- ☐ Other

Case Worker: _____ Phone:_____

Agency: _____

PLEASE PLACE THIS ON THE FRONT OF YOUR REFRIGERATOR

VITAL LINK

Information for Medical and Emergency Personnel

Please call if you need assistance with this form.

www.nyconnects.ny.gov

NEW YORK STATE | NY Connects
Your Link to Long Term Services and Supports
Clinton County
(800) 342-9871 (518) 565-4620

REMINDER
Please bring this packet with you WHENEVER you visit your doctor, the hospital, the emergency room, a health care provider or temporary shelter and ask them to help you keep it updated.
Additional items to be taken it you must leave your home in an emergency: medicines, medical equipment and supplies, such as oxygen. Make arrangements for your pets.

NAME (First, M.I., Last)	Date Completed/Revised
DOCTORS' NAME(S)	PHONE(home, cell, office)
Pharmacy Name, Address, and Phone #	
Mail Order Name, Address, and Phone #	

REV: 11/15

NAME (First, M.I., Last)			RED FLAGS
ADDRESS (Street, Apt. No/City/ State/ Zip Code)			
			ALLERGIES and REACTIONS (Include medications, food and environmental)
PHONE NO.	DATE OF BIRTH	NUMBER IN HOUSEHOLD	

CURRENT MEDICATIONS (including prescriptions and over-the-counter and herbal products) WRITE OR ATTACT CURRENT LIST

DRAW A LINE THROUGH ANY DISCONTINUED MEDICATIONS

MEDICATIONS	DOSAGE	FREQUENCY	DATE STARTED	ENDED	DOCTOR	NOTES (Reason for taking medication and any special Precautions for each medication, i.e. take on empty stomach)