



# Care Transitions Coalition within Winnebago County

## EMERGENCY CONTACT INFORMATION

(keep this with your personal health records and bring to any medical appointment)

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Advocate Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Email: \_\_\_\_\_

### Family contacts:

1) Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ email: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

2) Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ email: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

3) Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ email: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

4) Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ email: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

### Other contacts:

1) Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #1: \_\_\_\_\_

Address: \_\_\_\_\_

Email: \_\_\_\_\_ Phone #2: \_\_\_\_\_

2) Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #1: \_\_\_\_\_

Address: \_\_\_\_\_

Email: \_\_\_\_\_ Phone #2: \_\_\_\_\_

### Primary Care Provider:

Name: \_\_\_\_\_ Clinic: \_\_\_\_\_ Phone: \_\_\_\_\_

### Hospital:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_



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### Specialist Physicians:

Name: \_\_\_\_\_ Specialty: \_\_\_\_\_ Clinic: \_\_\_\_\_

Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Specialty: \_\_\_\_\_ Clinic: \_\_\_\_\_

Phone: \_\_\_\_\_

### Pharmacy:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

### Other Service Providers:

Insurance case manager: \_\_\_\_\_ Phone: \_\_\_\_\_

Home care agency/Personal care agency: \_\_\_\_\_ Phone: \_\_\_\_\_

Housekeeper/etc: \_\_\_\_\_ Phone: \_\_\_\_\_

Insurance Provider Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Policy #: \_\_\_\_\_ Member #: \_\_\_\_\_

### Other: (caregivers, church contact, other important information)

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