MEDICAL INTAKE FORM:

- DATE + TIME REGISTERED, VOLUNTEER NAME

- PATIENT NAME + AGE

- PATIENT ADDRESS + PHONE NUMBER OR OTHER CONTACT INFORMATION

- PRIMARY CARE PHYSICIAN + PHYSICIAN'S PHONE NUMBER OR OTHER CONTACT INFORMATION

- PHARMACY USED + PHARMACY CONTACT INFORMATION

- CURRENT MEDICAL NEEDS AND MEDICAL CONDITION

→ IF THIS IS AN EMERGENCY CALL 911

- PERTINENT PAST MEDICAL HISTORY

- MEDICATIONS IN SHORT SUPPLY:

- ALLERGIES

- RESOURCES

WORKING PHONE	**YES**	**NO**
POWER	**YES**	**NO**
HEAT	**YES**	**NO**
WATER	**YES**	**NO**
FOOD	**YES**	**NO**
FAMILY SUPPORT	**YES**	**NO**

- HEALTHCARE VOLUNTEER ASSESSMENTS + INTERVENTIONS (DATE + NOTES)

- STATUS UPDATES (DATE + NOTES)