

VENTURE OUT MEDIFILE PROGRAM

This program has been developed for an emergency situation, providing medical personnel with vital information which may save your life. However, it won't work if you do not follow all of these instructions.

1. A red magnetic envelope and medical information card may be obtained from the Activity Office. (Only one envelope per unit, however each resident should have an information card.) Additional information cards may be downloaded from the Venture Out website at:
www.ventureoutrvresort.com/pdfs/medifile.pdf
2. Complete the card. Print clearly. Use heavy **pencil** if your information is likely to change.
3. This information must be correct as it will determine your treatment. Have your doctor review it and always **keep it updated**.
4. You may make a copy of the information card to carry in your wallet.
5. If you have instructions for resuscitation or organ donations, attach these to the medical information card.
6. Insert completed information card(s) into the red magnetic envelope.
7. Place envelope on front door of refrigerator, so it can be easily seen by Emergency Services. They may wish to take the card to the hospital.
8. Medical information card(s) can be removed if needed. Magnetic envelope should remain on refrigerator door.

Additional Information: Any prior preparation re: wills, funerals or personal wishes can help make a tragic situation a little easier to handle. Having a copy of your living will and birth certificate in your unit may be helpful. You may wish to indicate the location of these on your medical information card or advise a neighbor or relative.

Medical Data

Please update as needed • Last updated on _____

Name: _____ Ph. _____

Date of Birth: _____ / _____ / _____ Sex: M F
Month Day Year

Doctor: _____ Ph. _____

Doctor: _____ Ph. _____

Doctor: _____ Ph. _____

EMERGENCY CONTACTS

Name: _____ Ph. _____

Name: _____ Ph. _____

Name: _____ Ph. _____

VO Resident: _____ Ph. _____

RECENT SURGERY

DATES

CURRENT MEDICATIONS

Problem	Meds	Dosage	Freq
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Location of Living Will: _____

ALLERGIES

- | | | |
|--------------------------------------|---------------------------------------|---------------------------------------|
| <input type="checkbox"/> ASPRIN | <input type="checkbox"/> INSECT STING | <input type="checkbox"/> PENICILLIN |
| <input type="checkbox"/> BARBITURATE | <input type="checkbox"/> LATEX | <input type="checkbox"/> SULFA |
| <input type="checkbox"/> CODEINE | <input type="checkbox"/> LIDOCAINE | <input type="checkbox"/> TETRACYCLINE |
| <input type="checkbox"/> HORSE SERUM | <input type="checkbox"/> MORPHINE | <input type="checkbox"/> XRAY DYES |
| <input type="checkbox"/> DERMATITIS | <input type="checkbox"/> ECZEMA | <input type="checkbox"/> NONE KNOWN |

ENVIROMENTAL: _____

FOOD: _____

OTHER: _____

MEDICAL CONDITIONS

- | | |
|---|---|
| <input type="checkbox"/> NO KNOWN CONDIDITION | <input type="checkbox"/> HEMOLYTIC ANEMIA |
| <input type="checkbox"/> ABNORMAL EKG | <input type="checkbox"/> HEPATITIS - TYPE () |
| <input type="checkbox"/> ADRENAL INSUFFICIENCY | <input type="checkbox"/> HYPERTENSION |
| <input type="checkbox"/> ANGINA | <input type="checkbox"/> HYPOGLYCEMIA |
| <input type="checkbox"/> ASTHMA | <input type="checkbox"/> LARYNGECTOMY |
| <input type="checkbox"/> BLEEDING DISORDER | <input type="checkbox"/> LEUKEMIA |
| <input type="checkbox"/> CANCER | <input type="checkbox"/> LYMPHOMAS |
| <input type="checkbox"/> CARDIAC DYSRHYTHMIA | <input type="checkbox"/> MEMORY IMPAIRED |
| <input type="checkbox"/> CATARACTS | <input type="checkbox"/> MYASTHENIA GRAVIS |
| <input type="checkbox"/> CLOTTING DISORDER | <input type="checkbox"/> PACEMAKER |
| <input type="checkbox"/> CORONARY BYPASS GRAFT | <input type="checkbox"/> RENAL FAILURE |
| <input type="checkbox"/> DEMENTIA | <input type="checkbox"/> SEIZURE DISORDER |
| <input type="checkbox"/> ALZHEIMERS | <input type="checkbox"/> SICKLE CELL ANEMIA |
| <input type="checkbox"/> DIABETES/Insulin dependent | <input type="checkbox"/> STROKE |
| <input type="checkbox"/> EYE SURGERY | <input type="checkbox"/> TUBERCULOSIS |
| <input type="checkbox"/> GLAUCOMA | <input type="checkbox"/> VISION IMPAIRED |
| <input type="checkbox"/> HEARING IMPAIRED | <input type="checkbox"/> _____ |
| <input type="checkbox"/> HEART VALVE PROSTHESIS | <input type="checkbox"/> _____ |
| <input type="checkbox"/> HEMODIALYSIS | <input type="checkbox"/> _____ |
| <input type="checkbox"/> OTHER | _____ |

FOLD HERE • STORE IN RED POUCH ON YOUR REFRIGERATOR