



**CHARLOTTE COUNTY  
RED DOT MEDICAL  
INFORMATION**



<b>FIRE/EMERGENCY MEDICAL SERVICES INFORMATION</b>			
NAME: _____		PHONE #: _____	
ADDRESS: _____		APT: _____	
CITY: _____		ZIP CODE: _____	
AGE: _____	DATE OF BIRTH: _____	SOCIAL SECURITY#: _____	
MEDICAL HISTORY: DO YOU HAVE A DO NOT RESUSCITATE ORDERS? _ Yes <input type="checkbox"/> No <input type="checkbox"/>			
<b>"IF YES, ATTACH TO YOUR YELLOW COPY"</b>			
CARDIAC: Yes <input type="checkbox"/> No <input type="checkbox"/>	PACEMAKER: Yes <input type="checkbox"/> No <input type="checkbox"/>	DIABETES: Yes <input type="checkbox"/> No <input type="checkbox"/>	INSULIN: Yes <input type="checkbox"/> No <input type="checkbox"/>
RESPIRATORY: Yes <input type="checkbox"/> No <input type="checkbox"/>	C.O.P.D. Yes <input type="checkbox"/> No <input type="checkbox"/>	CONGESTIVE HEART FAILURE Yes <input type="checkbox"/> No <input type="checkbox"/>	
CANCER Yes <input type="checkbox"/> No <input type="checkbox"/>	TYPE _____	HIGH BLOOD PRESSURE Yes <input type="checkbox"/> No <input type="checkbox"/>	
MAJOR SURGERIES: _____			
OTHER MEDICAL PROBLEMS: _____			
MEDICATIONS:			
1. _____	2. _____	3. _____	4. _____
5. _____	6. _____	7. _____	8. _____
9. _____	10. _____	11. _____	12. _____
ALLERGIES: _____			
PATIENT'S DOCTOR: _____		PHONE #: _____	

<b>HOSPITAL INFORMATION</b>	<b>HOSPITAL PREFERENCE:</b>
Do you have an ADVANCE DIRECTIVES: _____ If yes, please attach a copy to your Red Dot form.	
In the event that your Advance Directives are NOT available the intent of the Advance Directives are as follows:	
CPR: Cardiopulmonary resuscitation restarts your heart and lungs if you stop breathing or your heart stops. Yes <input type="checkbox"/> No <input type="checkbox"/>	
Ventilator: A machine that pumps oxygen into your lungs through a tube inserted into your windpipe. Yes <input type="checkbox"/> No <input type="checkbox"/>	
Tube Feeding: Provides food or fluid through a tube or IV if you cannot chew or swallow Yes <input type="checkbox"/> No <input type="checkbox"/>	
Kidney Dialysis: Cleans your blood by machine when your kidneys no longer work. Yes <input type="checkbox"/> No <input type="checkbox"/>	
Hospice Care: Comfort care such as oxygen, food, fluids by mouth given during the last stages of a terminal illness, nothing is done artificially to prolong your life. Yes <input type="checkbox"/> No <input type="checkbox"/>	
Pain Medication: Medications given, such as morphine and narcotics for your comfort. Yes <input type="checkbox"/> No <input type="checkbox"/>	
Signature: _____	Date: _____
Witness: _____	Date: _____

<b>9-1-1 INFORMATION</b>
Are you deaf or profoundly hard of hearing? Yes <input type="checkbox"/> No <input type="checkbox"/> Does not include hearing aids
Are you blind or sight impaired? Yes <input type="checkbox"/> No <input type="checkbox"/> Does not include wearing glasses
Key location if emergency services needs entry to home
Do you have a medical alert system? Yes <input type="checkbox"/> No <input type="checkbox"/>

<b>Emergency Contact Information:</b>
Name of emergency contact: _____ Telephone #: _____
Address: _____ City: _____ State: _____ Zip Code: _____
Relationship to emergency contact: (check one) <input type="checkbox"/> RELATIVE <input type="checkbox"/> FRIEND OTHER: _____
<b>CONTACT EMERGENCY MANAGEMENT (941) 505-4620 IF YOU HAVE SPECIAL NEEDS OR REQUIRE TRANSPORTATION ASSISTANCE DURING A HURRICANE EVACUATION.</b>

