

# Personal Information Sheet

Name:

Date of Birth:

Health Card Number:

Current Address:

Is this person able to give consent for treatment?

Yes    No

## Primary Contacts

(1) Family member/Next of Kin

Name:

Phone #:

(2) Prescribing physician

Name:

Phone #:

## Current medications

Name of Medication

Dose and frequency

## Personal Profile

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### Issues

### Prevention and/or management strategies

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(1) Physical Health Problems (e.g., allergies, illnesses)

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(2) Behaviors when distressed:

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(3) Mental health problems

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(4) Communication issues

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(5) intellectual /developmental issues

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Other personal considerations or risks:

Personal interests, preferences, likes/dislikes:

Skills & Abilities:

**Other Key Contacts**

Name:

Phone #:

Name:

Phone #:

Name:

Phone #: