Macomb County Community Mental Health Services

EMERGENCY MEDICAL FORM

THIS FORM IS COMPLETED IN ADDITION TO AN INCIDENT REPORT

Recipient: _____ Case Number: _____ Date: _____

**** Not to be used for planned hospital admissions or hospitalizations due to the natural course of a terminal illness***

List any interventions attempted prior to seeking emergency medical attention:
(Actual readings of vital signs taken and tests done, eg. blood sugar)

Amount of time between onset of symptoms and seeking emergency medical attention:

Who made the decision to seek emergency medical attention?

If taken to Urgent Care:
Name of Urgent Care facility that was used:

Result of Visit (including diagnosis and treatment given) (Include all lab results)

If taken to the Emergency Room:
Name of the hospital that was used:

Admitted to hospital: Y or N

What was the diagnosis:

Result of the visit:
(Include all lab results – give the test and the readings)

SIGNATURE OF PERSON COMPLETING REPORT	PRINT NAME AND TITLE	DATE
SIGNATURE OF LICENSEE/ADMINISTRATOR	PRINT NAME AND TITLE	DATE