

## Emergency Contact Tool (Example)

**Name:** Antonio Lopez

### First Contact

<b>Name:</b> Elena Lopez			
HOME NUMBER: (123) 569-8560		WORK NUMBER: (123) 745-7564	
CELL PHONE NUMBER: (123) 456-9709		PAGER NUMBER: (123) 456-8763	
RELATIONSHIP TO YOU: <input checked="" type="checkbox"/> Spouse/Partner <input type="checkbox"/> Child <input type="checkbox"/> Caregiver <input type="checkbox"/> Parent <input type="checkbox"/> Brother/Sister <input type="checkbox"/> Other (please describe): _____			
HOME ADDRESS: 4569 Congress Avenue			
CITY: Houston	STATE: Texas	ZIP CODE: 12345	COUNTRY: USA
ADDITIONAL INFORMATION: Works Monday – Friday from 8:00 am – 5:00 pm			

### Second Contact: (If first contact does not answer)



<b>Name:</b> Carlos Lopez			
HOME NUMBER: (123) 569-8560		WORK NUMBER: (123) 745-7564	
CELL PHONE NUMBER: (123) 456-9709		PAGER NUMBER: (123) 456-8763	
RELATIONSHIP TO YOU: <input type="checkbox"/> Spouse/Partner <input type="checkbox"/> Child <input type="checkbox"/> Caregiver <input type="checkbox"/> Parent <input checked="" type="checkbox"/> Brother/Sister <input type="checkbox"/> Other (please describe): _____			
HOME ADDRESS: 489 Austin Avenue			
CITY: Houston	STATE: Texas	ZIP CODE: 12345	COUNTRY: USA
ADDITIONAL INFORMATION: Works Wednesday – Sunday from 5:00 pm – 1:00 am			

**Insurance:**




INSURANCE COMPANY: Blue Cross Blue Shield of Texas	
POLICY NUMBER: 12345678	GROUP NUMBER: 0000
ADDITIONAL INFORMATION (Phone number, address, etc.):	

INSURANCE COMPANY: Medicaid	
POLICY NUMBER: 12345678	GROUP NUMBER: 0000
ADDITIONAL INFORMATION (Phone number, address, etc.):	

**Hospital:**

HOSPITAL: Houston Medical Center	
	ADDRESS: 120 Broad Street Houston, Texas 12345
	PHONE NUMBER: (123) 456-7890

**Doctor:**

DOCTOR'S NAME:			
NURSE'S NAME:			
	ADDRESS:		
	PHONE NUMBER:		FAX NUMBER:

# Emergency Contact Tool

Name: \_\_\_\_\_

## First Contact

NAME:			
HOME NUMBER:		WORK NUMBER:	
CELL PHONE NUMBER:		PAGER NUMBER:	
RELATIONSHIP TO YOU: <input type="checkbox"/> Spouse/Partner <input type="checkbox"/> Child <input type="checkbox"/> Caregiver <input type="checkbox"/> Parent <input type="checkbox"/> Brother/Sister <input type="checkbox"/> Other (please describe): _____			
HOME ADDRESS:			
CITY:	STATE:	ZIP CODE:	COUNTRY:
ADDITIONAL INFORMATION:			

## Second Contact: (If first contact does not answer)



NAME:			
HOME NUMBER:		WORK NUMBER:	
CELL PHONE NUMBER:		PAGER NUMBER:	
RELATIONSHIP TO YOU: <input type="checkbox"/> Spouse/Partner <input type="checkbox"/> Child <input type="checkbox"/> Caregiver <input type="checkbox"/> Parent <input type="checkbox"/> Brother/Sister <input type="checkbox"/> Other (please describe): _____			
HOME ADDRESS:			
CITY:	STATE:	ZIP CODE:	COUNTRY:
ADDITIONAL INFORMATION:			

**Insurance:**




INSURANCE COMPANY:	
POLICY NUMBER:	GROUP NUMBER:
ADDITIONAL INFORMATION: (phone number, address, etc.)	

INSURANCE COMPANY:	
POLICY NUMBER:	GROUP NUMBER:
ADDITIONAL INFORMATION (Phone number, address, etc.):	

**Hospital:**

HOSPITAL:	
	ADDRESS:
	PHONE NUMBER:

**Doctor:**

DOCTOR'S NAME:			
NURSE'S NAME:			
	ADDRESS:		
	PHONE NUMBER:		FAX NUMBER:



MEDICATION  
TOOLS

**CARMEN**, Cancer Survivor