A Proactive Community Health Care Initiative for Chattahoochee Hills Citizens

The person identified below is a resident of Chattahoochee Hills, GA, and should receive further consideration for CHATT Care routine monitoring and/or in the event of an emergency or required follow-up care by Fire/EMS personnel …

FIRST NAME: ____________________________ **LAST NAME:** _________________________________

PATIENT INFORMATION

☐ MALE ☐ FEMALE DOB: ___ / ___ / ___

RACE: ___________ HEIGHT: ____ WEIGHT: ____

Patient Phone

Phone #1 __________________

Phone #2 __________________

RESIDENCE ADDRESS ____

SPOUSE/GUARDIAN NAME ______________________________ Phone _____________________

SPOUSE/GUARDIAN SIGNATURE __________________________________ DATE __________

Patient Medical Information

EXPLAIN PRIMARY HEALTH CONCERNS: 1. ____
2. ____
3. ____

CHECK ALL THAT APPLY …

- ☐ Oxygen-dependent
- ☐ Diagnosis of extreme hypertensione
- ☐ LVAD cardiac support
- ☐ Non-ambulatory
- ☐ COPD (airway/lung disorder)
- ☐ Dialysis
- ☐ Recent critical surgery
- ☐ Congestive heart failure
- ☐ Amputation
- ☐ Bed-bound
- ☐ Dementia or Alzheimer's disease
- ☐ Debilitating arthritis
- ☐ Diabetes
- ☐ Cancer (terminal)
- ☐ Pacemaker
- ☐ Stroke / Recovery
- ☐ History of A or V fibrillation
- ☐ Hepatitis / HIV / AIDS
- ☐ Other life-threatening/debilitating conditions: ____

FOOD ALLERGIES
1. _____________________
2. _____________________
3. _____________________

MEDICINE ALLERGIES
1. _____________________
2. _____________________
3. _____________________

OTHER ALLERGIES
1. _____________________
2. _____________________
3. _____________________

PRESCIRIPTION MEDICATIONS
1. _____________________
2. _____________________
3. _____________________
4. _____________________
5. _____________________
6. _____________________
7. _____________________
8. _____________________
9. _____________________
10. _____________________

OVER-COUNTER MEDICATIONS
1. _______________________
2. _______________________
3. _______________________

Primary Physician: ___________________________________

Location where patient receives primary care or majority of care: ___________________________________

PATIENT(S) TRAUMA / SPECIAL INFORMATION

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SPECIAL CARE INSTRUCTIONS BY PHYSICIAN

1. ____

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2. ____

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3. ____

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4. ____

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5. ____

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FIRE DEPT ADMIN USE ONLY

Submitted by: ____ Phone Number: ________________________
Family Member / Guardian/ Affiliate

Date Received: ________________ APPROVED by: ____
(Fire Officer)

Identification on file: ☐ YES ☐ NO Program/System Entry Date: ____________________

Required follow-up: ____

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