VIAL OF LIFE (VOL) INFORMATION

Date Prepared: ____ /____ /________
Name: ___________________________
*__Preferred Name__ : _________________
Year of Birth: ________
Sex: ___ Male ___ Female
Driver's License:
State: ____________
Number: _______________________

Primary Care Physician:
Name: _________________________
Phone: _________________________

Specialty Physician:
Name: _________________________
Specialty: ______________________
Phone: _________________________

Insurance:
_____ Medicare
_____ Other (name):
___ Primary ________________
___ Secondary ______________

In Case of Emergency (ICE) Contacts:
Primary:
Name: ________________________
Relationship: __________________
Home Phone: __________________
Cell Phone: ___________________
Work Phone: __________________
(√) ___ Next of Kin: ___ Alternate:
Name: _________________________
Relationship: __________________
Home Phone: ___________________
Cell Phone: ____________________
Work Phone: ___________________

Advanced Care Plan / Physician Orders for Scope of Treatment (POST):
State Prepared: _________________
On file with:
___ Primary Care Physician (above)
___ Specialty Physician (above)
___ Primary ICE Contact (above)
___ NOK/Alternate ICE Contact (above)
___ Other Name: ________________
Phone: __________________

CURRENT MEDICAL ISSUES (√)

___ AIDS/HIV
___ Arthritis
___ Asthma
___ Cancer
___ Dementia/Alzheimers
___ Diabetes
___ Emphysema/COPD
___ Glaucoma
___ Hearing Impairment/Deaf
___ Heart Issues
___ Hepatitis
___ High Blood Pressure (Hypertension)
___ Parkinson's
___ STD ___________________________
___ Visually Impaired
___ Other _________________________
___ Other _________________________

MEDICAL HISTORY / HISTORY OF:

___ Congestive Heart Failure
___ Heart Attack
___ Seizure disorder
___ Stroke
___ Other _________________________

HEALTH AID DEVICES

___ Cane/Walker
___ Contacts
___ Glasses
___ Hearing Aid
___ Pacemaker
___ Other ______________________

MEDICATION ALLERGIES

___ Name ______________________
___ Name ______________________

RECENT SURGERIES

- Date: ____ /_____ /________
  Surgery: _______________________
- Date: ____/ _____ /________
  Surgery: _______________________

COMPLETE Form VOL 2-2 FOR CURRENT MEDICATION LIST

Form VOL 2-1 (3/23/2017)

INSTRUCTIONS FOR USE

1. Use separate form[1] for each user.
2. Your name on this form is that name on your driver's license or primary ID.
*Your "preferred name" is that name to which you best respond.
2. Print and fill out form OR, fill out on your computer, then print. Make or print copies (1 copy for each vial).
3. Cut out VOL information block on the solid lines, then fold on the dashed lines.
4. Roll up forms for each person and insert into VOL containers for home and car(s).

IMPORTANT!

1. Notify your designated "*In Case of Emergency*" (ICE) contacts as necessary, executing a new VOL form[1] if this information changes. ENSURE YOUR ICE CONTACTS ARE AWARE AND AGREE TO BEING DESIGNATED AS SUCH. Provide each ICE contact a completed form.
2. Execute a new VOL form[1] each time any change is made in medical information or points of contact. Destroy (shred) any expired form.
3. Fill out and sign an "In Case of Emergency" Contact Form for each ICE contact and provide an ORIGINAL, signed form to each contact.

[1]Forms may be obtained:
- on-line at: www.FGRServices.org (programs/Vial of Life),
- picked up at the FGRS Office
- or email request to: FGRSoffice@frontier.com