



Operation Red File

Please review every 6 months



BASIC INFORMATION				
Full Legal Name			Phone Number	
Home Mailing Address				
Date of Birth		Funeral Home of Choice:		
Gender	Height	Weight	Hair Color	Eye Color
EMERGENCY CONTACTS				
Name and Phone Number		Relationship	May we release your health information to this person?	
Name and Phone Number		Relationship	May we release your health information to this person?	
MEDICAL INFORMATION				
Hearing Aids?	Deaf/ Very Hard of Hearing?	Glasses/Contacts?	Blindness?	Primary Language
Identifying Marks/Tattoos				
Conditions you have been treated for in the past				
Primary Physician & Phone Number			Hospital Choice	
Medication Allergies				
Current Medical Conditions you are being treated for				
<i>For the questions below, please complete all that apply. Please note current providers, phone numbers and locations of pertinent documents.</i>				
DNR (Do Not Resuscitate) Order		Living Will	Other Pertinent Medical Information	
Hospice Care		Dialysis Care		

Please use the back of this form if needed