Date Form Completed: _____

Emergency Information

Resident's Name: _____DOB: _____Apt#_____

Social Security Number (optional but will be needed for Madrona Grove Admission): _____

Do you have an Advance Directive? Yes_____ No ☐
(location)

Do you have a POLST form? Yes _____Registry#: _____ No ☐
(location)

Organ Donor? Y☐ ☐N Mortuary: _____

Insurance Information:
Medicare Number: _____

Additional Insurance Coverage:
Provider:_____ ID #_____

Designated Health Care Decision Maker
We will notify this person if you go to the hospital or have another emergency health issue. This person is able to make healthcare decisions on your behalf when you are unable to do so.

Name: _____ Relationship: _____

Home Ph: _____ Work Ph: _____ Mobile Ph: _____

Address: _____City: _____ State: _____ Zip: _____

Email: _____

Note: If you are in Madrona Grove, this person is invited to quarterly care conferences and will receive notifications regarding changes in condition or care.

Alternate Health Care Decision Maker (if any)
This person is able to make healthcare decisions on your behalf when both you and your Designated Healthcare Decision Maker are unable to do so.

Name: _____ Relationship: _____

Home Ph: _____ Work Ph: _____ Mobile Ph: _____

Address: _____City: _____State: _____ Zip: _____

Email: _____

Designated Financial Decision Maker

This person will pay bills and will make decisions regarding financial matters on your behalf when you are not able to do so.

Name: _____ Relationship:_____

Home Ph:_____ Work Ph:_____Mobile Ph: _____

Address: _____City: _____ State: _____ Zip: _____

Email: _____

Other Contacts

These are other people in your life with whom you authorize Rose Villa to share information about your healthcare, such as additional family members, friends, and Rose Villa residents not otherwise listed above.

Name: _____ Relationship: _____

Primary Phone: _____ Email: _____

Name: _____ Relationship: _____

Primary Phone: _____ Email: _____

Provider Contact Information

This information is used to facilitate your care in the event that you are unable to do so.

Primary Care Physician: _____ Phone: _____

Dentist: _____ Phone: _____

Other Provider: _____ Type: _____ Phone: _____

Any other information, pertaining to the contacts, that you would like us to know about:

_____

_____

_____

You may update this information at any time by contacting:
MaryHelen Clausing, ext. 3044, mclausing@rosevilla.org
Erica Schafer, ext. 2324, eschafer@rosevilla.org