

# Home Care Agency Name

Home Care Agency Address



## Emergency Kardex

<b>Clinician Name:</b> Jane Doe	<b>Patient Name:</b> John Doe	<b>Gender:</b> M
<b>DOB:</b> 01/15/1950	<b>Mobile Phone:</b> 212-718-9005	<b>Home Phone:</b> —
<b>Address:</b> 101 Bedford Avenue, Brooklyn, NY		

⚠ If you are evacuated, this form MUST be brought to the shelter ⚠

### Patient Information

<b>Priority Code:</b>	Level 2 — Moderate (needs scheduled care)
<b>TAL Status:</b>	TAL-2 Wheelchair

### Contact Information

Contact Type	Name	Address	Phone	Fax
Local Emergency Contact	John Smith — Friend	101 Bedford Avenue, Brooklyn, NY	212-718-9006	
Primary Physician	Dr. John Smith, NPI: 0000000000	101 Bedford Avenue, Brooklyn, NY	212-718-9007	

### Advance Directives

<b>Advance Directives:</b>	<input type="checkbox"/> None <input checked="" type="checkbox"/> Healthcare Proxy <input type="checkbox"/> DNR
<b>Other:</b>	—

### Nutritional Requirements

<b>Nutritional Requirements:</b>	<input type="checkbox"/> Regular/No Restrictions <input type="checkbox"/> Cardiac <input type="checkbox"/> Pureed <input type="checkbox"/> Low Sodium <input type="checkbox"/> Low Fat <input type="checkbox"/> Low Cholesterol <input type="checkbox"/> Low Sugar <input type="checkbox"/> No Concentrated Sweets <input type="checkbox"/> High Fiber <input checked="" type="checkbox"/> Soft <input type="checkbox"/> Renal <input type="checkbox"/> 1800 Cal ADA
<b>Other:</b>	—

### Allergies

<b>Allergies:</b>	Medication Allergies: NKDA. Food Allergies: NKA. Substance/Environmental Allergies: NKA
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### DME and Supplies

<b>DME and Supplies:</b>	<input type="checkbox"/> None <input type="checkbox"/> Cane <input type="checkbox"/> Quad Cane <input type="checkbox"/> Walker <input type="checkbox"/> Wheelchair <input type="checkbox"/> Hospital Bed <input type="checkbox"/> Bedside Commode <input checked="" type="checkbox"/> Shower Chair <input checked="" type="checkbox"/> Grab Bars <input type="checkbox"/> Hand Rails <input checked="" type="checkbox"/> Shower Rails <input type="checkbox"/> Hoyer Lift <input type="checkbox"/> Bed Rails <input type="checkbox"/> Adjustable Bed <input type="checkbox"/> Trapeze Bar <input type="checkbox"/> Sleeps In Recliner <input type="checkbox"/> Oxygen & Supplies <input type="checkbox"/> BiPAP <input type="checkbox"/> CPAP <input type="checkbox"/> Ventilator <input type="checkbox"/> Tracheostomy <input type="checkbox"/> Glucometer / Strips <input type="checkbox"/> Wound Care Supplies <input type="checkbox"/> Incontinence Supplies
<b>Other:</b>	Rollator



**Please Bring the Following Items to the Shelter**

- 7–10 days' supply of medication / medical supplies / special equipment (walker, wheelchair)
- Special dietary foods
- Blankets or sleeping bags
- Flashlights and batteries
- Portable radio and batteries
- Extra clothing
- Lightweight folding chairs and cots
- Personal care items
- Important papers, including identification
- Home chart (including physician orders)

**Advanced Directives Acknowledgement**

Emergency Plan Discussed?

Yes  No

**Advanced Directives Acknowledgement:**

I acknowledge that I have received the Advanced Directives Packet. I have been asked whether or not I have an advanced directive, and I have been advised of the possible limitation of Home Care Agency personnel who may not be able to implement an advanced directive on the basis of conscience. I am also aware that personnel may not participate with the withdrawal of any life sustaining care or service.



RN Signature

Jane Doe

RN Name

02/09/2026

Date