PLEASE make extra copies of the attached forms

BEFORE filling out one set of the forms to keep in the “VIAL OF LIFE”.

Extra blank copies can be printed off the website www.gnrcaaad.org

On the left side of the GNRC AAAD home page, click on the Forms tab, then click on the “Vial of Life” button for copies of the attached blank pages #1 through #5.
VIAL OF LIFE

This ‘Vial of Life’ has been designed to contain vital medical information about you. It is to be (1) used by medical personnel in case of an emergency, (2) used by you when you go to your doctor, (3) take with you if you have to evacuate your home.

Place the ‘Vial of Life’ on the top shelf of your refrigerator, right side. Be sure you have rolled the “Medical Data” page so that your name shows through the outside of the tube. We suggest you keep a passport size picture of yourself in the Vial. Only enter the last 4 digits of your Social Security Number.

Your Vial should contain the five pages attached to this page called: (1) Your Medical Data; (2) Your Medical History and Medical Conditions; (3) Universal Medication Form;(4)&(5) Advance Care Plan.

In an Emergency, if you can talk and get to a phone, DIAL 9-1-1 and give the following:

1. Name and phone number;

2. Address of Emergency;

3. Description of Emergency;

4. Stay on line until the dispatcher hangs up;

5. If possible, have someone stand outside to direct help;

6. Or, if you carry one, hit your emergency response button.

Keep Vial information current: it can save your life.
Your MEDICAL DATA (Please PRINT) UPDATED ___/___/_____

Your NAME___________________________________________

Your DATE of BIRTH___/___/_______

Your SOCIAL SECURITY NUMBER _xxx_ - _xx_ - ______

Your BLOOD TYPE_______

Where, in the house, are your medicines located? __________________________

How do you communicate with others? ____spoken language; ____sign language; ____story board; ____other – explain __________________________________________________________________

What LANGUAGE(s) DO YOU USE? (1)___________________(2)_______________________

Your ‘normal’ blood pressure: ____/____

Do you USE OXYGEN? YES NO

Do you wear eyeglasses? YES NO

Do you wear CONTACT LENSES? YES NO

Do you wear a hearing aid(s)? YES NO

Do you wear false teeth or a removable bridge? YES NO

Your PRIVATE HEALTH INSURANCE NAME_________________________________,

Your PRIVATE HEALTH INSURANCE NUMBER & Phone ________________________.

Your MEDICAID (TENNCARE) #______________________

Your HOSPITAL PREFERENCE____________________________________________

In Case of Emergency, Contact FIRST _____________________; Best Phone__________.

In Case of Emergency Contact ALTERNATE______________; Best Phone__________.

Your NEXT OF Kin _____________________________; Phone_____________________.

Your MAIN Doctor________________________________; Phone__________________

Your SECONDARY Doctor________________________; Phone____________________

Your Pet’s NAME _____________________________
Your MEDICAL HISTORY and MEDICAL CONDITIONS:

( ) No known medical conditions

<table>
<thead>
<tr>
<th>Condition</th>
<th>Condition</th>
<th>Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>( ) Abnormal EKG</td>
<td>( ) Dementia</td>
<td>( ) Hypoglycemia</td>
</tr>
<tr>
<td>( ) Adrenal insufficiency</td>
<td>( ) Diabetes/Insulin Dependence</td>
<td>( ) Laryngectomy</td>
</tr>
<tr>
<td>( ) Alzheimer’s</td>
<td>( ) Eye Surgery</td>
<td>( ) Leukemia</td>
</tr>
<tr>
<td>( ) Angina</td>
<td>( ) Glaucoma</td>
<td>( ) Lymphomas</td>
</tr>
<tr>
<td>( ) Asthma</td>
<td>( ) Hard of Hearing/Deaf</td>
<td>( ) Memory Impaired</td>
</tr>
<tr>
<td>( ) Cardiac Dysrhythmia</td>
<td>( ) Heart Disease</td>
<td>( ) Myasthenia Gravis</td>
</tr>
<tr>
<td>( ) Cancer</td>
<td>( ) Heart Valve Prosthesis</td>
<td>( ) Pacemaker</td>
</tr>
<tr>
<td>( ) Cataracts</td>
<td>( ) Hemodialysis</td>
<td>( ) Renal Failure</td>
</tr>
<tr>
<td>( ) Clotting Disorder</td>
<td>( ) Hemolytic Anemia</td>
<td>( ) Respiratory</td>
</tr>
<tr>
<td>( ) Coronary Bypass Graft</td>
<td>( ) Hypertension</td>
<td>( ) Seizures</td>
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<tr>
<td></td>
<td></td>
<td>( ) Sickle Cell Anemia</td>
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<tr>
<td></td>
<td></td>
<td>( ) Stroke/TIA</td>
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<tr>
<td></td>
<td></td>
<td>( ) Vision Impaired</td>
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<tr>
<td>( ) Other</td>
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<tr>
<td>( ) Other</td>
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</tbody>
</table>

Recent Surgery___________________________________; Date__________

In an EMERGENCY, if you must leave home, what medical equipment needs to go with you?

__________________________________________________________________________
UNIVERSAL MEDICATION FORM

Date form started: ____________

Keep this form in the Vial of Life. Take it with you to the doctor, pharmacy and hospital.

Name:                  Address:
Phone Number:          
Birth Date:             
Emergency Contact/Phone numbers:

<table>
<thead>
<tr>
<th>IMMUNIZATION RECORD</th>
<th>(Record the date/year of last dose taken, if known)</th>
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</thead>
<tbody>
<tr>
<td>TETANUS</td>
<td>FLU VACCINE(S)</td>
</tr>
<tr>
<td>PNEUMONIA VACCINE</td>
<td>HEPATITIS VACCINE</td>
</tr>
<tr>
<td></td>
<td>OTHER</td>
</tr>
</tbody>
</table>

Allergic To / Describe Reaction:  Allergic To / Describe Reaction:

LIST ALL MEDICINES YOU ARE CURRENTLY TAKING: Prescription and over-the-counter medications (examples: aspirin, antacids) and herbals (examples: ginseng, gingko). Include medications taken as needed (example: nitroglycerin).

<table>
<thead>
<tr>
<th>DATE</th>
<th>NAME OF MEDICATION / DOSE</th>
<th>DIRECTIONS: Use patient friendly directions. (Do not use medical abbreviations.)</th>
<th>DATE STOPPED</th>
<th>Notes: Reason for taking / Doctor Name</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

For additional copies go to www.tnpharm.org.
ADVANCE CARE PLAN

Instructions: Competent adults and emancipated minors may give advance instructions using this form or any form of their own choosing. To be legally binding, the Advance Care Plan must be signed and either witnessed or notarized.

I, ____________________________________, hereby give these advance instructions on how I want to be treated by my doctors and other health care providers when I can no longer make those treatment decisions myself.

**Agent:** I want the following person to make health care decisions for me:

Name: _____________________________ Phone #:  _____________ Relation: _____________________
Address: ____________________________________________________________________________________

**Alternate Agent:** If the person named above is unable or unwilling to make health care decisions for me, I appoint as alternate:

Name: _____________________________ Phone #:  _____________ Relation: _____________________
Address: ____________________________________________________________________________________

**Quality of Life:**

I want my doctors to help me maintain an acceptable quality of life including adequate pain management. A quality of life that is unacceptable to me means when I have any of the following conditions (you can check as many of these items as you want):

- **Permanent Unconscious Condition:** I become totally unaware of people or surroundings with little chance of ever waking up from the coma.
- **Permanent Confusion:** I become unable to remember, understand or make decisions. I do not recognize loved ones or cannot have a clear conversation with them.
- **Dependent in all Activities of Daily Living:** I am no longer able to talk clearly or move by myself. I depend on others for feeding, bathing, dressing and walking. Rehabilitation or any other restorative treatment will not help.
- **End-Stage Illnesses:** I have an illness that has reached its final stages in spite of full treatment. Examples: Widespread cancer that does not respond anymore to treatment; chronic and/or damaged heart and lungs, where oxygen needed most of the time and activities are limited due to the feeling of suffocation.

**Treatment:**

If my quality of life becomes unacceptable to me and my condition is irreversible (that is, it will not improve), I direct that medically appropriate treatment be provided as follows. **Checking “yes” means I WANT the treatment. Checking “no” means I DO NOT want the treatment.**

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th><strong>CPR (Cardiopulmonary Resuscitation):</strong></th>
<th>To make the heart beat again and restore breathing after it has stopped. Usually this involves electric shock, chest compressions, and breathing assistance.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>No</td>
<td><strong>Life Support / Other Artificial Support:</strong></td>
<td>Continuous use of breathing machine, IV fluids, medications, and other equipment that helps the lungs, heart, kidneys and other organs to continue to work.</td>
</tr>
<tr>
<td>Yes</td>
<td>No</td>
<td><strong>Treatment of New Conditions:</strong></td>
<td>Use of surgery, blood transfusions, or antibiotics that will deal with a new condition but will not help the main illness.</td>
</tr>
<tr>
<td>Yes</td>
<td>No</td>
<td><strong>Tube feeding/IV fluids:</strong></td>
<td>Use of tubes to deliver food and water to patient’s stomach or use of IV fluids into a vein which would include artificially delivered nutrition and hydration.</td>
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</tbody>
</table>
Other instructions, such as burial arrangements, hospice care, etc.: __________________________________________

__________________________________________________________

(Attach additional pages if necessary)

Organ donation (optional): Upon my death, I wish to make the following anatomical gift (please mark one):

- Any organ/tissue
- My entire body
- Only the following organs/tissues: _______________________

__________________________________________________________

SIGNATURE

Your signature should either be witnessed by two competent adults or notarized. If witnessed, neither witness should be the person you appointed as your agent, and at least one of the witnesses should be someone who is not related to you or entitled to any part of your estate.

Signature: ____________________________________________  DATE: _________________

(Patient)

Witnesses:

1. I am a competent adult who is not named as the agent. I witnessed the patient’s signature on this form.

Signature of witness number 1

2. I am a competent adult who is not named as the agent. I am not related to the patient by blood, marriage, or adoption and I would not be entitled to any portion of the patient’s estate upon his or her death under any existing will or codicil or by operation of law. I witnessed the patient’s signature on this form.

Signature of witness number 2

This document may be notarized instead of witnessed:

STATE OF TENNESSEE
COUNTY OF ________________________________

I am a Notary Public in and for the State and County named above. The person who signed this instrument is personally known to me (or proved to me on the basis of satisfactory evidence) to be the person who signed as the “patient”. The patient personally appeared before me and signed above or acknowledged the signature above as his or her own. I declare under penalty of perjury that the patient appears to be of sound mind and under no duress, fraud, or undue influence.

My commission expires: ________________________  Signature of Notary Public

WHAT TO DO WITH THIS ADVANCE DIRECTIVE

- Provide a copy to your physician(s)
- Keep a copy in your personal files where it is accessible to others
- Tell your closest relatives and friends what is in the document
- Provide a copy to the person(s) you named as your health care agent

Approved by Tennessee Department of Health, Board for Licensing Health Care Facilities, February 3, 2005
Acknowledgement to Project GRACE for inspiring the development of this form.