Newsday Tuesday
S M T W T F S

News Release

April 15, 2014

EMS 'GO PACKET' PROGRAM LAUNCH

PERFECT FOR INDIVIDUALS WITH SERIOUS MEDICAL CONDITIONS OR ALLERGIES TO MEDICATIONS

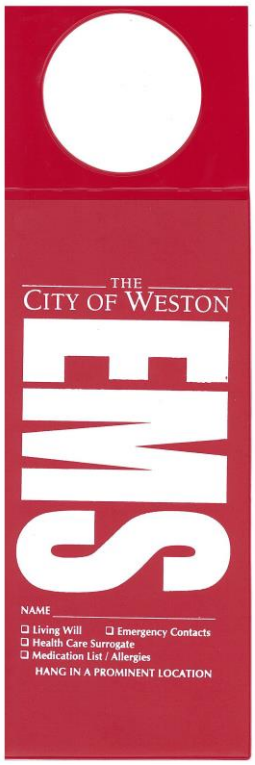
Weston Launches EMS Go Packet Initiative

During an emergency, when seconds count, important medical and legal information may not be readily available for fire fighters, paramedics and receiving hospital staff. The Broward Sheriff's Office Department of Fire Rescue is proud to partner with the City of Weston and Attorneys for H.O.P.E, Inc. (Health Options, Planning & Empowerment) to provide residents with the EMS Go Packet.

The EMS Go Packet is designed to contain all of your important medical information as well as important legal documents to ensure that during an emergency, the EMS and hospital personnel not only provide you with the highest level of medical care, but are also aware of and adhere to your rights as a patient. Attorneys for H.O.P.E., Inc.'s legal staff are available to provide residents with advanced care directives, such as a durable power of attorney, health care surrogate designation, donor forms and other applicable legal documents free of charge.

Completed EMS Go Packets should be placed in a conspicuous location, such as on the inside handle of your front door. The packet "jacket" is designed to hang on a door knob.

EMS Go Packets are available to all Weston residents free of charge and can be obtained by calling Fire Station 81 at (954) 389-2015.



Broward Sheriff Fire Rescue
EMS Go Packet Information Checklist

IMPORTANT - KEEP INFORMATION UP TO DATE
PLACE ALL PERTINENT DOCUMENTS INSIDE THIS EMS Go Packet

You may download an additional copy of this form at www.westonfl.org

PERSONAL INFORMATION: Date of Birth: _____ Male ☐ Female ☐
First Name: _____ Last Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____

EMERGENCY CONTACT:
First Name: _____ Last Name: _____
Telephone #_____ Relationship: _____

MEDICAL DATA: Primary Doctor: _____ Telephone #_____
Additional Doctor(s): _____ Telephone #_____

Preferred Hospital: _____ Blood Type: _____

Current Medical Conditions (check all that apply)
☐ No known medical conditions ☐ Abnormal EKG ☐ Adrenal Insufficiency ☐ Alzheimer's ☐ Angina ☐ Asthma ☐ Blood Disorder ☐ Cancer ☐ Cardiac Dysrhythmia ☐ Cataracts ☐ Clotting Disorder ☐ Coronary Bypass Graft ☐ Dementia ☐ Diabetes / Insulin Dependent ☐ Eye Surgery ☐ Glaucoma ☐ Hearing Impaired ☐ Heart Valve Prosthesis ☐ Hemodialysis ☐ Hemolytic Anemia ☐ Hepatitis – Type [ ] ☐ Hypertension ☐ Hypoglycemia ☐ Leukemia
☐ Lymphomas ☐ Memory Impaired ☐ Myasthenia Gravis ☐ Pacemaker ☐ Renal Failure ☐ Seizure Disorder ☐ Sickle Cell Anemia ☐ Stroke ☐ Tuberculosis ☐ Vision Impaired ☐ Other _____

Allergies
☐ No known allergies ☐ Aspirin ☐ Barbiturate ☐ Codeine ☐ Demerol ☐ Horse Serum ☐ Insect Stings ☐ Latex ☐ Lidocaine ☐ Morphine ☐ Novocaine ☐ Other: _____
☐ Penicillin ☐ Sulfa ☐ Tetracycline ☐ X-Ray Dyes

CURRENT MEDICATIONS:

MEDICATION	DOSAGE	FREQUENCY

MEDICAL INSURANCE: Insurance Company: _____ Telephone # _____
Policy # _____ Medicare # _____ Medicaid # _____

LEGAL DOCUMENTS CHECKLIST:
Please include copies of all legal documents:
☐ Living Will
☐ Durable Power of Attorney
☐ Health Care Surrogate
☐ Uniform Donor Form
☐ DNR (Original must be included in EMS Go Packet)

Peace of mind

Broward Sheriff Fire Rescue
EMS Go Packet Information Checklist

IMPORTANT - KEEP INFORMATION UP TO DATE
PLACE ALL PERTINENT DOCUMENTS INSIDE THIS EMS Go Packet

You may download an additional copy of this form at www.westonfl.org

PERSONAL INFORMATION:

Date of Birth: _____ **Male** □ **Female** □

First Name: _____ **Last Name:** _____
Address: _____
City: _____ **State:** _____ **Zip Code:** _____

EMERGENCY CONTACT:

First Name: _____ **Last Name:** _____
Telephone # _____ **Relationship:** _____

LEGAL DOCUMENTS CHECKLIST:

Please include copies of all legal documents:

- ❑ Living Will
- ❑ Durable Power of Attorney
- ❑ Health Care Surrogate
- ❑ Uniform Donor Form
- ❑ DNR (Original must be included in EMS Go Packet)

MEDICAL DATA:

Primary Doctor: _____ **Telephone #** _____
Additional Doctor(s): _____ **Telephone #** _____

Preferred Hospital: _____ **Blood Type:** _____

Current Medical Conditions (check all that apply)

- ❑ No known medical conditions
- ❑ Abnormal EKG
- ❑ Adrenal Insufficiency
- ❑ Alzheimer's
- ❑ Angina
- ❑ Asthma
- ❑ Blood Disorder
- ❑ Cancer
- ❑ Cardiac Dysrhythmia
- ❑ Cataracts
- ❑ Clotting Disorder
- ❑ Coronary Bypass Graft
- ❑ Dementia
- ❑ Diabetes / Insulin Dependent
- ❑ Eye Surgery
- ❑ Glaucoma
- ❑ Hearing Impaired
- ❑ Heart Valve Prosthesis
- ❑ Hemodialysis
- ❑ Hemolytic Anemia
- ❑ Hepatitis – Type [ ]
- ❑ Hypertension
- ❑ Hypoglycemia
- ❑ Leukemia
- ❑ Lymphomas
- ❑ Memory Impaired
- ❑ Myasthenia Gravis
- ❑ Pacemaker
- ❑ Renal Failure
- ❑ Seizure Disorder
- ❑ Sickle Cell Anemia
- ❑ Stroke
- ❑ Tuberculosis
- ❑ Vision Impaired
- ❑ Other _____
  _____

Allergies

- ❑ No known allergies
- ❑ Aspirin
- ❑ Barbiturate
- ❑ Codeine
- ❑ Demerol
- ❑ Horse Serum
- ❑ Insect Stings
- ❑ Latex
- ❑ Lidocaine
- ❑ Morphine
- ❑ Novocaine
- ❑ Other: _____
- ❑ Penicillin
- ❑ Sulfa
- ❑ Tetracycline
- ❑ X-Ray Dyes

CURRENT MEDICATIONS:

MEDICATION	DOSAGE	FREQUENCY

MEDICAL INSURANCE:

Insurance Company: _____ **Telephone #** _____

Policy # _____ **Medicare #** _____ **Medicaid #** _____