ABC's of Applied Behavior Analysis, Inc.
Lissa D. Hoprich, MA, BCBA
Ph: (540) 588-9582
Fax: (540) 380-8155
abcsofaba@gmail.com
1630 Braeburn Dr.
Salem, VA 24153

Emergency/Medical Information

Person Completing Form: _____ **Date This Form Completed:** _____

Client Name: _____ **Date of Admission:** _____

Client's Address: _____

SSN: _____ **Gender:** _____ **Marital Status:** _____ **DOB:** _____

Legal Status (legal guardian, adjudicated legal incapacity, etc…): _____

Parent/Guardian Name: _____

Home Telephone: _____ **Cell/Work Phone:** _____

Insurance Provider: _____ **Policy #:** _____

Secondary Provider (such as Medicaid, Medicare, or CHAMPUS)_____**Policy #:**_____

Physician: _____ **Telephone:** _____

Address: _____

Preferred Hospital/Clinic: _____

Emergency Contact/Relationship: _____

Emergency Contact Address/Phone: _____

Allergies (food and/or medication): _____

Substance Abuse History: _____

Significant Medical History Problems: _____

Significant Ambulatory/Sensory Problems: _____

Significant Communication Problems: _____

Does client have an advanced medical directive? **No** **Yes, and it is attached**

Is client at risk for falling because of medical, medication or emotional/behavioral concerns? **No** **Yes**

List all medications/dosages and reason for each:

Parent or guardian signature gives ABC's of Applied Behavior Analysis permission to obtain emergency medical treatment.

_____ _____

Parent/Guardian Signature **Date** **Witness Signature** **Date**