AFMC RESPONSE TO OPIOID CRISIS

IF YOU ARE IN CRISIS OR REQUIRE URGENT MEDICAL ATTENTION, PLEASE CONTACT 911

IN CASE OF EMERGENCY

Name: _____

Language: ❑ English ❑ French ❑ Other: _____

Address: _____ Phone Number: _____

Emergency Contact: _____ Relationship: _____ Phone Number: _____

Family Physician: _____ Phone Number: _____

Pharmacy Name: _____ Phone Number: _____

Health Card Number: _____ Date of Birth: ____/____/____

MEDICAL HISTORY:

❑ Heart Attack (date of most recent): _____
❑ Stroke
❑ Pacemaker
❑ Angina
❑ High Blood Pressure
❑ Chronic Obstructive Pulmonary Disorder
❑ Congestive Heart Failure
❑ Diabetes
❑ Implanted Defibrillator
❑ Asthma
❑ Seizures
❑ Others: _____

Current Medication (prescription, non-prescription, vitamins, supplements), **Dosage**, **Reason for Use**:

_____ _____
_____ _____
_____ _____
_____ _____
_____ ❑ Additional medications on back of page.

Allergies: _____

_____

Recent **Surgeries**: _____

_____

Any other relevant information: _____

_____

AFMC THE ASSOCIATION OF FACULTIES OF MEDICINE OF CANADA

Health Canada Santé Canada

This project has been made possible through a financial contribution from Health Canada. The views expressed herein do not necessarily represent the views of Health Canada.

IN CASE OF EMERGENCY

Current Medication (prescription, non-prescription, vitamins, supplements), **Dosage**, **Reason for Use**: