Medical Transport Communication Document for Person with Intellectual and/or Developmental Disability

This patients has intellectual and/or developmental disabilities or cognitive impairments.
It is medically necessary and essential to his/ her care to be transported with a support person.

Note: detailed information (problem list, medications, insurance can be found in the binder that must accompany the individual

Information related to this incident should be completed first. If information is unknown or not available when filling out form, leave blank.

Name:		Likes to be called:		DOB:
Reason for transport/ ambulance? (what happened that resulted in needing to go to the hospital)				
Any medication given for this problem? Dose? Time?				
Any vital signs checked at home?	BP _____/_____	HR	RR	O_2 Sat
Things that might trigger me or make me especially uncomfortable?				
Things that might help me?				
My typical behavior?				
How I communicate *(circle one):*	Verbal	Nonverbal	Sign Language	Other
Contact who can answer questions about recent health status (NAME)				(Contact #)
Does this individual have legal capacity to make their own healthcare decisions? **YES or NO**				
If no, Legal Guardian/Decision maker if no guardian (NAME)				(Contact #)
Primary Care Doctor (NAME)				(Contact #)
Code Status (circle one):	Full Code	DNR	DNR/DNI	Other
Living arrangement (circle one):	Group Home	Family Residence	Community Residence	

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