Stacia Poole, MD, LLC
930 S. Harbor City Blvd, Ste 101
Melbourne, FL 32901
321-752-1599 or 321-207-8454

Emergency Contact Form / HIPAA

In case of an emergency, who should we contact on your behalf?

1. _____ relationship: _____ Ph: _____

2. _____ relationship: _____ Ph: _____

Do you have a living will or advance directive? Yes ____ No ____

If yes, does this document specify any limitations for care in the event of any emergency (such as no blood products or transfusions, no intubation /ventilator, no CPR or resuscitation in the event of cardiac arrest)? If so, please document below and discuss these wishes with Dr. Poole. Yes ____ No ____

_____

If yes, does the document specify someone to have medical power of attorney (POA) for your affairs (ie; someone designated to make decisions about your care and consent to procedures if you are unable to)?

Yes ___ No___ **3.** Named POA: _____

Yes ___ No ___ Has this individual actively assumed the role as your decision maker or POA?

Do you give our office and Dr. Poole permission to discuss your medical condition and information about your care with any family members or close friends? Yes _____ No _____

If yes, please provide names and contact information below if known:

☐ Same as #1 listed above. ☐ Same as #2 listed above. ☐ Same as #3 listed above.

☐ Name: _____ relationship:_____ Ph: _____

☐Name: _____ relationship:_____ Ph: _____

☐ Name:_____ relationship:_____ Ph:_____

The phone number listed as your primary phone in our records is the one we will use for appointment reminders, to convey results of your labwork, or to contact you regarding billing issues. Please notify our receptionist in the event of a change in your primary contact number.
Is there an alternate number that we may try if we need to contact you regarding a schedule change or appointment reminder? _____ ☐ cell ☐work ☐ landline ☐family member _____

May we leave personal information on your answering machine or voicemail? Yes ___ No ___

May we use your email to contact you, give appointment reminders, or send medical info? Yes ___ No ___

Patient Name: _____ POA Name: _____

_____ _____
Signature Date

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