



Virginia Hospital Center-Arlington

LIFELINE INFORMATION FORM

LAST NAME _____ FIRST NAME _____ INITIAL _____
ADDRESS _____
CITY _____ STATE _____ ZIPCODE _____
PHONE () _____ SEX: (M_) (F_) BIRTH DATE _____

MEDICAL INFORMATION

ALLERGIES _____
PRIMARY PHYSICIAN _____ PHONE () _____
PREFERRED HOSPITAL _____
MEDICAL CONDITIONS (Please check those that apply):
 High Blood Pressure Diabetes Heart Disease
 Smoker History of falls Balance problems
 Pacemaker Use oxygen Hearing problems
 Vision problems Use walking device (walker, cane etc)
 Recent surgery/hospitalization (please list) _____
 Other _____

BILLING INFORMATION

BILL TO (If self, write self and leave the rest of this section blank)
LAST NAME _____ FIRST NAME _____ INITIAL _____
ADDRESS _____
CITY _____ STATE _____ ZIPCODE _____
HOME PHONE () _____ WORK PHONE () _____

CONTINUES ON BACK →

RESPONDER INFORMATION

Please list friends, family or neighbors that can come check on you if you need help:

1) LAST NAME _____ FIRST NAME _____
ADDRESS _____
CITY _____ STATE _____ ZIPCODE _____
HOME PHONE () _____ WORK PHONE () _____
CELL PHONE () _____ HAVE KEYS? (Yes___) (No___)
MINUTES AWAY _____ RELATIONSHIP _____

2) LAST NAME _____ FIRST NAME _____
ADDRESS _____
CITY _____ STATE _____ ZIPCODE _____
HOME PHONE () _____ WORK PHONE () _____
CELL PHONE () _____ HAVE KEYS? (Yes___) (No___)
MINUTES AWAY _____ RELATIONSHIP _____

3) LAST NAME _____ FIRST NAME _____
ADDRESS _____
CITY _____ STATE _____ ZIPCODE _____
HOME PHONE () _____ WORK PHONE () _____
CELL PHONE () _____ HAVE KEYS? (Yes___) (No___)
MINUTES AWAY _____ RELATIONSHIP _____

ADDITIONAL INFORMATION

NEXT OF KIN (We will notify them if you use your Personal Help Button
and/or are taken to the hospital) _____

ADDRESS _____

CITY _____ STATE _____ ZIPCODE _____

HOME PHONE () _____ WORK PHONE () _____