# Emergency Communication 4 ALL .....Picture Communication Aid

FREE SPACE *(for your custom message)*

I can't speak but I can hear and understand you.

My technology needs to be charged.

My vital information is on the back on this page.

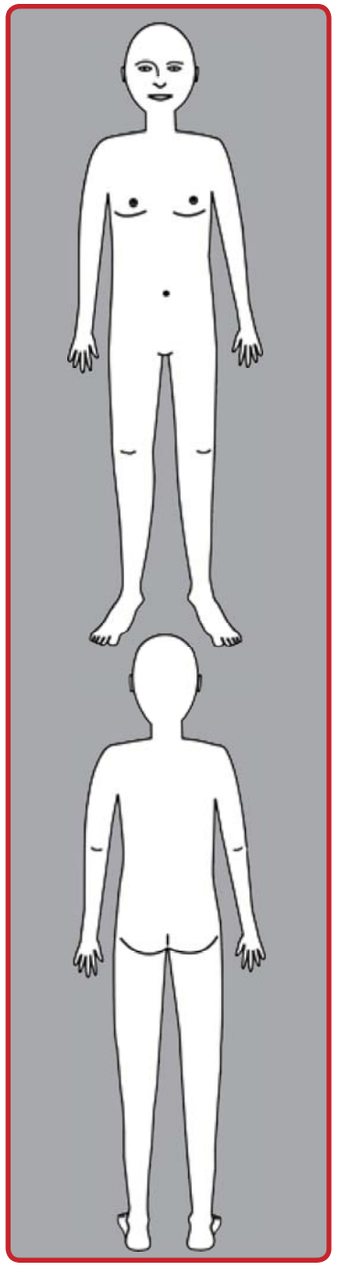
Please contact my family.

Ask me questions if you need to, but please wait patiently for my replies.

I will point to where I hurt.

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| MY NAME IS | I, me, my | Bleed | Infect | Allergy | Disability | Help | Bathroom |
| WHO | You, yours | Broken | Need/Want | Blanket | Disaster | Home | Walker |
| WHERE | She, her, hers | Burn | Rescue | Clothes | Emergency | Hospital | Wheelchair |
| WHAT | He, his, him | Choke | Spell | Cold | Family | Sick | Wind |
| WHEN | They, them, their | Communicate | Talk | Damage | Fire | Pets | Worried |
| WHY | We, ours | Evacuate | Understand | Danger | Flood | Shelter | Worse/Worst |
| HOW | YES | Hurt/Injure | Wait | Communication Device | Heat/Hot | Seizure | NO |

| | | | | |
|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 |
| 5 | 6 | 7 | 8 | 9 |
| A | B | C | D | E |
| F | G | H | I | J |
| K | L | M | N | O |
| P | Q | R | S | T |
| U | V | W | X | Y |
| Z | ? | . | !! | SPACE |



# Emergency Communication 4 ALL

## PERSONAL INFORMATION

**1. NAME** _____

DOB _____

Address _____

Cell Phone _____

Home Phone _____

Email _____

**2. EMERGENCY CONTACT**

Name _____

Address _____

Cell Phone _____

Home Phone _____

Relation _____

**3. 2ND EMERGENCY CONTACT**

Name _____

Address _____

Cell Phone _____

Home Phone _____

Relation _____

**4. DOCTOR**

Name _____

Address _____

Phone _____

**5. HEALTH INSURANCE**

❑Private ❑Medicare ❑Medicaid ❑Other _____

Policy Number _____

Date Issued _____

**6. PRESCRIPTION MEDICATIONS**

Name & Dosage _____

Name & Dosage _____

Name & Dosage _____

Name & Dosage _____

Name & Dosage _____

**7. OVER THE COUNTER DRUGS**

1) _____

2) _____

**8. PHARMACY NAME** _____

Contact Person _____

Phone _____

**9. ALLERGIES** [complete list] _____

**10. RELEVANT MEDICAL HISTORY** [brief] _____

**11. SUPPORT AGENCY** [if applicable] _____

**12. MEDICAL EQUIPMENT/TECHNOLOGY SUPPLIER**

**13. EQUIPMENT/SUPPORT NEEDED FOR INDEPENDENCE**

**Personal Assistance Services**

Name _____

Phone _____

Allotted Hours _____

**Mobility/Transferring** _____

**Communication** _____

**Hygiene/Toileting /Vision** _____

**Telephone Use** _____

**Finances/Writing** _____

**Cooking** _____

**Eating and Diet** _____

**Transportation** _____

**Service Animals** _____

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