Sutter Auburn Faith Hospital

A Sutter Health Affiliate

Sutter Roseville Medical Center

A Sutter Health Affiliate

VIAL OF LIFE

Date Form Completed: ___________

PERSONAL INFORMATION

Name: Age: Date of Birth:

Address:

Gender: ❑ Male ❑ Female

City:

Zip Code: SSN#:

Phone: Weight:

Emergency Contact Name: Emergency Contact Phone:

Physician Name: Physician Phone:

Health Insurance: Policy #:

MEDICAL INFORMATION

Do you have an active Do Not Resuscitate (DNR)? (If yes, please attach?) ❑ Yes ❑ No

Do you have an Advanced Health Care Directive? ❑ Yes ❑ No

Are you an organ donor? ❑ Yes ❑ No

Name of Designated Agent: Agent's Phone:

Medical Conditions: Check all that apply.

✓		✓	
	AIDS		**Epilepsy**
	Allergies		**Glaucoma**
	Anemia		**Heart Disease**
	Asthma		**Hemophilia**
	Cancer		**Hypoglycemia**
	Diabetes		**Stroke**
	Emphysema		
	High Blood Pressure		**Low Blood Pressure**

Medications: (Name and Dose) Please list or attach.

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