

LIFELINE CARE PLAN PREP SHEET

Please have the following information available and contact our office at **360-788-6748** to schedule an installation, or email it to us at **Lifeline@PeaceHealth.org**

First Name		Middle	Last Name		Preferred Name
Household Phone # (360)		Language Need?	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		Date Of Birth
Residential Street Address/Apt.#			City	State	Zip Code
Building Name	PO BOX		Contact for Scheduling:		
Household Hidden Key Location		Directions to Home		<input type="checkbox"/> Multiple Subscriber Household	
				<i>A separate Care Plan is needed for each Subscriber</i>	
Drug Allergies		Medical Conditions and/or Diseases		Household Warnings	
Responder One		Responder Two		Responder Three	
Name (First/Last)		Name (First/Last)		Name (First/Last)	
Street Address		Street Address		Street Address	
City, State, Zip Code		City, State, Zip Code		City, State, Zip Code	
Family Relation		Family Relation		Family Relation	
Phone <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell ()		Phone <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell ()		Phone <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell ()	
Phone <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell ()		Phone <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell ()		Phone <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell ()	
Phone <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell ()		Phone <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell ()		Phone <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell ()	
Notify			Notify		
Name (First/Last)		Family Relation	Name (First/Last)		Family Relation
<input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell ()		<input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell ()	<input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell ()		<input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell ()
Primary Physician			Referral Source		
Name		Phone # ()	Name/Title		Phone # ()
Other Notes:					
Payer Information					
First Name		Last name		Phone # ()	
Address			City	State	Zip Code