Four Winds SARATOGA
a psychiatric health system

MEDICAL EMERGENCY CONSENT

		DATE OF ADMISSION
PATIENT'S NAME	AGE	DATE OF BIRTH
(MOTHER/GUARDIAN) FOR MINOR PATIENT	(FATHER / GUARDIAN) FOR MINOR PATIENT	
PATIENT / PARENT / GUARDIAN ADDRESS		
PATIENT / PARENT / GUARDIAN TELEPHONE (HOME)	BUSINESS	
PATIENT'S PHYSICIAN	MD TELEPHONE	
ADDRESS		

EMERGENCY INFORMATION

KNOWN ALLERGIES
CURRENT MEDICATIONS
DATE OF LAST TETANUS BOOSTER

AUTHORIZATION

1. I authorize Four Winds Saratoga to provide emergency treatment to _____ and to provide emergency room transportation to Saratoga Hospital.

2. I authorize Saratoga Hospital to provide emergency room treatment to _____.
3. I authorize Saratoga Hospital/Saratoga Care Wilton Medical Arts to exchange information with Four Winds Saratoga to coordinate my care and exchange information relating to my care at both facilities. This release will expire 10 days after I have been discharged from Four Winds Saratoga, unless I request differently.

I understand that in the event of any emergency situation Four winds Saratoga will make all attempts to notify the following person(s) and the above stated physician. In the event I am not able to authorize the hospital to notify the following person(s), I authorize Four Winds Saratoga to notify the following persons:

NAME	Phone (AM)	(PM)
ADDRESS		
RELATIONSHIP TO PATIENT		
NAME	Phone (AM)	(PM)
ADDRESS		
RELATIONSHIP TO PATIENT		

SIGNATURE OF PATIENT, PARENT OR GUARDIAN: _____ DATE: _____

WITNESS / TITLE: _____DATE: _____