

VAD: My Emergency Contact Information

Patient Name: _____

Date of Birth: _____

Address: _____

Phone Number: _____

Patient's Email Address: _____

911 Responder:
(Name and Phone Number) _____

Local Hospital/Emergency Room:
(Name and Phone Number) _____

- I have willingly provided the above information and give my permission to have the information above shared with my local Emergency Room and EMS Provider.

Patient Signature:

Disclaimer: This document contains information and/or instructional materials developed by Michigan Medicine for the typical patient with your condition. It may include links to online content that was not created by Michigan Medicine and for which Michigan Medicine does not assume responsibility. It does not replace medical advice from your health care provider because your experience may differ from that of the typical patient. Talk to your health care provider if you have any questions about this document, your condition or your treatment plan.

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