



CAPSULE OF LIFE®

EM 2118 (R2004-05) B

INSTRUCTIONS

1. Fill out this information sheet completely and legibly. (Get assistance, if required.)
2. When complete, roll up the information sheet and place in the Capsule.
3. Attach the Capsule underneath the top shelf of your refrigerator on the right-hand side.
4. Place the "Capsule of Life" decal on the outside of the refrigerator.

KEEP THIS INFORMATION UP TO DATE			
DATE FILLED IN (YYYY-MM-DD)		DATE UPDATED (YYYY-MM-DD)	
FIRST NAME		MIDDLE NAME	LAST NAME
SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		MARITAL STATUS <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> SINGLE <input type="checkbox"/> WIDOW(ER)	
ADDRESS (STREET NUMBER)		APARTMENT NUMBER	
CITY/TOWN		PROVINCE	POSTAL CODE
TELEPHONE NUMBER		BIRTH DATE (YYYY-MM-DD)	
HEIGHT	WEIGHT		HAIR COLOUR
ALBERTA HEALTH CARE NUMBER		BLUE CROSS NUMBER	
<input type="checkbox"/> DO YOU WEAR A MEDIC ALERT TAG? IF SO, FOR WHAT CONDITION?			
IN CASE OF EMERGENCY NOTIFY			
NAME			
ADDRESS			
TELEPHONE NUMBER		RELATIONSHIP	
NAME			
ADDRESS			
TELEPHONE NUMBER		RELATIONSHIP	

ALL EMERGENCY PERSONNEL			
TO: _____		DATE _____	
FROM: _____		MD _____	
GOALS OF CARE DESIGNATION ORDERS			
The patient/guardian and the physician responsible for the care of the patient have agreed that due to the following reason(s) we request that resuscitation efforts be limited to the following:			
TREATMENT REQUESTED:			
R Medical Care and Interventions including Resuscitation followed by Intensive Care	<input type="checkbox"/>	R1	Patient is expected to benefit from and is accepting of any appropriate investigations/interventions that can be offered including the option of ICU care and resuscitation.
	<input type="checkbox"/>	R2	Patient is expected to benefit from and is accepting of any appropriate investigations/interventions that can be offered including the option of ICU care and intubation, but excluding chest compression.
	<input type="checkbox"/>	R3	Patient is expected to benefit from and is accepting of any appropriate investigations/interventions that can be offered including the option of ICU care, but excluding intubation and chest compression.
M Medical Care and Interventions, excluding Resuscitation	<input type="checkbox"/>	M1	Goals of Care and interventions are for cure or control of illness, excluding the option of ICU care. For non-hospital patients, transfer to an Acute Care facility is considered if required for diagnosis and treatment.
	<input type="checkbox"/>	M2	Goals of Care and interventions are for cure or control of illness, excluding the option of ICU care. For non-hospital patients, transfer to an Acute Care facility or surgical intervention, are not generally undertaken for an acute deterioration but may be considered in special circumstances to better understand or control symptoms.
C Medical Care and Interventions, focused on Comfort	<input type="checkbox"/>	C1	Goals of Care and interventions are for maximal symptom control and maintenance of function without cure or control of underlying condition. Transfer may be undertaken in order to better understand or control symptoms. Surgery may be undertaken in special circumstances to better understand or control symptoms.
	<input type="checkbox"/>	C2	Goals of Care and interventions are for physical, psychological and spiritual preparation for imminent death (usually within hours or days). Maximal efforts directed at compassionate symptom control. Transfer is usually not undertaken.
Reason for Goals of Care Designation Order/patient diagnosis (Please print): _____ _____ _____			
SIGNATURE OF PATIENT/GUARDIAN		PATIENT/GUARDIAN NAME (PRINT)	
SIGNATURE OF PHYSICIAN		PHYSICIAN NAME (PRINT)	
PLEASE REFER TO BACK FOR DETAILS			

DETACH CARD, FOLD ALONG DOTTED LINE AND PLACE IN WALLET.

CAPSULE OF LIFE WALLET CARD	
Name: _____	
Address: _____	
Phone: _____	
Physician / Phone: _____	
Emergency Contact: _____	
Phone: _____	

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KEEP THIS INFORMATION UP TO DATE		
FIRST NAME	MIDDLE NAME	LAST NAME
DOCTOR'S NAME		
HOSPITAL PREFERRED		NAME OF PHARMACY USED
BLOOD TYPE		DO YOU WEAR CONTACT LENSES?
DO YOU HAVE		
<input type="checkbox"/> HEART TROUBLE?	<input type="checkbox"/> HIGH BLOOD PRESSURE?	<input type="checkbox"/> DIABETES?
<input type="checkbox"/> LUNG TROUBLE?	<input type="checkbox"/> KIDNEY DISEASE?	<input type="checkbox"/> LIVER DISEASE?
ANY OTHER DISEASES?		
ANY ALLERGIES?		
PAST SURGERY?		
LIST ALL MEDICATION, DOSAGE TAKEN AND DATE PRESCRIBED		
MEDICATION	DOSAGE	DATE PRESCRIBED YYYY-MM-DD
TO WHICH MEDICATION(S) ARE YOU ALLERGIC?		

GOALS OF CARE DESIGNATION ORDERS

- a.** To be considered valid, Goal of Care Designation order must:
- (1) Be on paper which is identified as authentic:
 - Goals of Care Designation order form (103547)
 - Sunrise Clinical Manager (Acute Care Patient Care Information System) print-out of electronic order
 - Letterhead (AHS, CHR, EMS, physician, institutional)
 - Prescription pad (personalized)
 - (2) Include the following information:
 - Date
 - Patient's name, date of birth, address
 - Physician's name (print)
 - Physician's signature
 - Instructions for Goals of Care Designation
 - (3) Be presented to the EMS Crew Chief
- b.** Verbal orders will be accepted from a valid physician on scene or by telephone
- c.** When no written Goal of Care Designation orders are present, the decision to resuscitate or not lies with the Crew Chief as guided by the Medical Control Protocols
- d.** The Crew Chief may elect to contact the Base Hospital Physician in difficult situations

Please visit

<http://www.calgaryhealthregion.ca/advancecareplanning> for further information or any questions/concerns you may have.

PLEASE KEEP UP TO DATE

Alberta Health Care Number: _____

Medications: _____

Allergies: _____
