HIPAA PERMITS DISCLOSURE TO HEALTH CARE PROFESSIONALS & ELECTRONIC REGISTRY AS NECESSARY FOR TREATMENT

Oregon Health Emergency Protocol

Patient's Last Name:	Suffix:	Patient's First Name:	Patient's Middle Name:
Date of Birth: (mm/dd/yyyy): _____/_____/_____	Pronouns:	Address (street/city/zip):	

HEALTH EMERGENCY MANAGEMENT RECOMMENDATIONS:

Use the field below to describe actions that should be taken by Emergency Department providers in response to a specific medical emergency for a patient with complex physical health and/or mental health condition(s). This may include: primary and secondary diagnoses, medications/fluids/specific treatments, and contact information for emergency consult.

ATTESTATION of MD/DO/NP/PA/ND (REQUIRED)

*By signing below, I attest that these care recommendations are the **current** best course of action for the patient should they experience a medical emergency involving the complex physical health and/or mental health condition(s) described above.*

MD/DO/NP/PA/ND Printed Name: **required**	Signer's Phone Number:	Consult Phone Number:
MD/DO/NP/PA/ND Signature: **required**	Date Signed: **required**	Signer's License Number: