epilepsy southwestern ontario

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797 York St., Unit 3
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www.epilepsyswo.ca
Charitable registration number:
11890 0802 RR0001

Vulnerable Persons Identification Form

Basic Information	
First Name:	Last Name:
Address:	City:
Unit/Apartment #:	Province:
Postal Code:	Phone #:
Email:	Gender identity:
Current living arrangements: ☐ Alone ☐ With family ☐ Facility ☐Other *(please describe)*:	
Language(s) spoken *(please list and indicate first language)*:	

Appearance & Physical Description	
Height:	Weight:
Shoe size:	Eye colour:
Hair colour:	Dominant hand: ☐ Right ☐ Left
Complexion:	
Hair style *(i.e. curly, straight, bangs, etc)*:	
Facial hair *(describe the style if applicable)*:	
Distinguishing features – *(i.e. tattoos, scars, birth marks, etc)*:	
Speech habits/idiosyncrasies *(i.e. accent, talks with a stutter, etc)*:	

Health and Wellness	
Hearing aid(s) or cochlear implant(s)? ☐ Hearing aid(s) ☐ Cochlear implant(s) ☐ Right ☐ Left ☐ Neither	
Wear glasses or contacts? ☐ Yes ☐ No	Dentures: ☐ Upper ☐ Lower ☐ None
Mobility: ☐ Cane ☐ Wheelchair ☐ Walker ☐ Scooter ☐ No assistive devices ☐ Other *(please describe)*:	
Risk factors: ☐ Suicidal ☐ Confused ☐ Frustrated ☐ Depressed ☐ Other *(please describe)*:	

Surgeries or procedures in the last five years? If so, please list:	
Allergies – please list, including any food allergies or sensitivities:	
Medications – please list:	Self-prescribed medications *(i.e. vitamins, herbs, dietary supplements) – please list*:
Results of not taking medications:	

Medical Information	
OHIP #:	Version:
Family Doctor:	Phone #:
Neurologist/Epileptologist:	Phone #:
Any Other Physicians That Should Be Notified? 1 2 3	
Type of seizure(s) 1 2 3	
What to expect from the seizure(s) (i.e. behaviours before, during, and after seizures):	
Typical length of seizures:	
Personality post seizure:	
Seizure Triggers – please list any known triggers:	

How to respond to the seizure(s) - *(i.e. basic seizure first aid, or responding to their wandering [may need space or may need to be redirected])*:	
How to communicate with the person – *(what is helpful/comforting)*:	
How NOT to communicate with the person – *(what should be avoided)*:	
Any prescribed rescue medication:	
Do you have a Do Not Resuscitate Form in place *(DNR)*:	
If so, where is it?	
Is a tracking device in use? ☐ Yes ☐ No	Is there a Power of Attorney? ☐ Yes ☐ No
If so, who is the POA?	Name:
Phone #:	Email:
Emergency Contact Information	
First Name:	Last Name:
Relationship:	Phone Number:
Address:	
Alternate Emergency Contact Information	
First Name:	Last Name:
Relationship:	Phone Number:
Address:	
If there is an emergency, do you grant consent for us to release this information to the relevant authorities (EMS, physician)?	
Signature:	Date (MM/DD/YYYY)

If you have any questions, comments, or concerns, please reach out to:
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