Consumer's Face Sheet Information

Consumer's Information

Name:_____ D.O.B.: _____ Gender: _____

Height:_____ Weight:_____ Eye Color:_____ Hair Color:_____

Ambulatory Status: _____ Conserved By:_____

Diagnosis / Medical Concerns:

Allergies or Precautions:

Residence

Home: _____ Home #: _____

Address:_____ Zip:_____

Primary Contact:_____ Cell #:_____ Other#:_____

Secondary Contact:_____ Cell #:_____ Other#:_____

Other Contact:_____ Cell #:_____ Other#:_____

Other Contacts

Emergency Contact: _____ Relationship:_____

Address: _____ Zip:_____

Home #: _____ Cell #:_____ Other#:_____

Emergency Contact: _____ Relationship:_____

Address: _____ Zip:_____

Home #: _____ Cell #:_____ Other#:_____

Transportation Company: _____Contact:_____

Address: _____ Zip:_____

Home #: _____ Cell #:_____ Other#:_____

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Consumer's Face Sheet Information

Medical Provider Information

UCI # _____ Medi-Cal #_____ Medi-Care #_____

Specialty Equipment or Medical Supplies Needed:

Doctors

Name: _____ Specialty: _____

Address: _____ Zip:_____

Office #: _____ Other # _____

Physicians

Doctor's Name: _____ Specialty: _____

Address: _____ Zip:_____

Office #: _____ Other # _____

Doctor's Name: _____ Specialty: _____

Address: _____ Zip:_____

Office #: _____ Other # _____

Doctor's Name: _____ Specialty: _____

Address: _____ Zip:_____

Office #: _____ Other # _____

Pharmacy

Name: _____

Address: _____ Zip:_____

Office #: _____ Other # _____

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Consumer's Face Sheet Information

ID Team Members

Unyeway, Inc. Case Manager: _____

Instructor/Coach: _____ Site: _____

Component: _____ Date of Admission: _____

Component: _____ Date of Transfer: _____

Component: _____ Date of Transfer: _____

Component: _____ Date of Transfer: _____

San Diego Regional Center Service Coordinator: _____

Location: _____ Phone #: _____ Fax #:_____

Address: _____ Zip:_____

Conservator: _____ Relationship:_____

Address: _____ Zip:_____

Home #: _____ Cell #:_____ Other#:_____

Residential Administrator: _____

Office Address: _____ Zip:_____

Home #: _____ Cell #:_____ Other#:_____

Residential Nurse: _____

Office Address: _____ Zip:_____

Home #: _____ Cell #:_____ Other#:_____

Behavior Specialist: _____

Location: _____ Phone #: _____ Fax #:_____

Address: _____ Zip:_____

Other: _____ Relationship:_____

Address: _____ Zip:_____

Home #: _____ Cell #:_____ Other#:_____