

**Citizen Call Check (C.C.C.) Application &
Senior Residents/Infirm/Infrmed/Special Needs**

Medical Questionnaire & Update

Name: _____ Today's Date: _____

Address: _____ Sea Isle City, NJ 08243

Telephone Number: _____ Date of Birth: _____

Family Physician: _____ Telephone Number: _____

Family Pharmacy: _____ Telephone Number: _____

PERSONAL MEDICAL INFORMATION

Please list all prescription medication that you are presently taking: _____

PLEASE HAVE MEDICINE AVAILABLE FOR EASY ACCESS, (IN CASE OF AN EMERGENCY)

In an emergency situation or fire, will you need assistance to evacuate your dwelling: YES NO

ARE YOU:

LIVING ALONE? YES NO
AMBULATORY? YES NO
IN A WHEEL CHAIR? YES NO
BEDRIDDEN? YES NO

DO YOU HAVE:

HOSPICE CARE: YES NO
VISITING NURSE CARE YES NO
REGULAR ASSISTANCE: YES NO
A PET? YES NO

Cat _____ Dog _____ OTHER _____

In the event of an emergency, what is your hospital preference? _____ Cape Regional Medical Center

_____ Shore Memorial Hospital

Please list any special medical conditions or personal medical requirements: _____

Closest Relative to be notified: and/or Closest Friend to be notified:.

Name: _____

Address: _____

City, State, Zip _____

Telephone Number: _____

Relationship: _____