

## Further Key Details (optional)

### Previous key address(es)

Details of previous address(es)

### Employment details / Previous employment

Detail name and address of present or previous employer

### Places of interest

Detail any places of interest that you visit often or have visited in the past

### Habits / Hobbies

Detail any habits and / or hobbies that you regularly enjoy

### Pets

Do you have any pets at home, and if so, what kind?

### Mobile phone

Do you have a mobile phone? If YES, please enter the number

### Data Protection

Permission to share information with relevant emergency and health care providers (please tick (✓) one box)

YES  NO

## Please remember to ...

1. Ensure the form is completed, dated and signed.
2. A separate form must be completed for each person in the household who lives with an illness or allergy: ask for extra forms when you receive your pack.
3. Place the bottle in your fridge, **in a door compartment**, where it will be safe and quickly found.
4. Place the green cross sticker on the outside of the fridge door.
5. Stick the other label on the **inside of your front door** at eye level and in line with your door lock if possible.
6. Ensure that your current prescription is with your medication.
7. Keep medication in a box.

## Are there any other details that may be required by the emergency services?

- Special instructions concerning your medication
- Special medical aids
- Communication difficulties
- Religion
- Hearing or visual problems

If you have a personal information folder, it contains important information that will help Emergency Services/Hospital staff. Please list it here and where it is kept:

## Emergency Treatment & Escalation Plan

Advanced Care and Treatment Plan	<input type="checkbox"/>	HAP Care Plan (Health Action Plan)	<input type="checkbox"/>
Where is it located?	<input type="text"/>	The Herbert Protocol	<input type="checkbox"/>
		Do Not Resuscitate Info	<input type="checkbox"/>

This form was completed by	<input type="text"/>
Relationship (if not completed by you)	<input type="text"/>
All the information is correct to the best of my knowledge and I accept that it is my responsibility to ensure that ALL the information on this form is kept up to date.	
Signed	<input type="text"/>
Print Name	<input type="text"/>
Date	<input type="text"/>



# Lions Message in a Bottle

## The bottle found in the fridge

### We Serve – We Care. Sponsored by your local Lions Club

This is a voluntary scheme for anyone living at home, who might be reassured to know that essential information would be readily available to the Emergency Services, not only to identify you, but to advise on relevant illnesses, allergies, medication and contact addresses, should you suffer an accident or sudden illness.

### When time is saved, lives are saved

When Emergency Services see medical information and personal details of a patient, they can then render safer and speedier First Aid by short cutting time-consuming fact-finding enquiries about the patient.

### What do you have to do?

Complete the form overleaf in ballpoint pen using BLOCK CAPITALS. Date and sign the form before placing it in the bottle.

**A separate form** must be filled in for each person in the household who has an illness or allergy; ask for extra forms when you receive your pack.

### Supported by

Ambulance, Police, Fire & Rescue Services, Emergency Doctors, NHS Primary Care Trusts.

*Disclaimer* Lions Clubs International MD105 do not accept any responsibility for the details inserted on this form or for any additional paperwork included in the bottle.



## Personal details

NHS No.  Date of Birth  Age

Surname  Gender

First Name(s)

Postcode  Preferred Language

### Do you have a Medic Alert pendant or bracelet?

Member No.

Diagnosis/Conditions I have

### Do you take medicine for?

Asthma	<input type="checkbox"/>	Dementia	<input type="checkbox"/>	Heart Problem	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	Parkinson's	<input type="checkbox"/>	Anti-Coagulant	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	Motor-Neurone (MN)	<input type="checkbox"/>	Multiple Sclerosis (MS)	<input type="checkbox"/>
Other	<input type="checkbox"/>	I have communication problems	<input type="checkbox"/>	I need hearing aids	<input type="checkbox"/>

### Your medication

Where do you keep your medication?

Room

Location

**Important** - Always keep your repeat prescription with your medication. Keep your medication in a box.

## Photograph

**Important**  
Place a recent photograph here

### Illness

Detail any illness or drug therapy that might affect emergency treatment

### Allergic reaction to medication

Detail any allergic reaction to medication you take

### Allergies

Detail any allergies you have

## Your Doctor's details

Name of GP

Practice Address

Tel No.

## Your Carer/Your Carer's Agency details

Name

Organisation Address

Tel/Mobile No.

## Emergency contact 1

Name  Relationship

Contact Address

Contact Tel No.

## Emergency contact 2

Name  Relationship

Contact Address

Contact Tel No.