Child's Name and H+C No

EMERGENCY HEALTH CARE PLAN - EHCP

To all NIAS/Paramedic/A+E staff			
Name:		**DOB:**	
Address:		**HCN:**	
		Weight:	

EMERGENCY CONTACT NUMBERS		
Name	**Relationship**	**Contact Number**

DIAGNOSIS

DOCTOR WHO KNOWS PATIENT BEST			
Name:		**Contact Number:**	

TYPE OF EMERGENCY TREATMENT REQUIRED FOR IMMEDIATELY REVERSIBLE CAUSES
eg. Choking, Anaphylaxis, Blocked tracheostomy, Seizure (please state)

KNOWN ALLERGIES

THINGS THAT SHOULDN'T BE DONE

ACTIONS TO BE TAKEN IN THE EVENT OF CARDIORESPIRATORY ARREST

PREFERRED PLACE OF DEATH (if appropriate)

Child/Parent [PR] signature: _____ **Date:** _____

Doctor signature: _____ **Date:** _____

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SUMMARY OF CONDITION
Including diagnosis and expected trajectory.
Medical devices in situ (eg. VP shunt, PEG, NG, Tracheostomy, Baclofen pump, VNS device, pacemaker etc)

SALIENT POINTS
eg. Deaf, blind, no verbal communication but able to understand, use of electronic communication device.

MEDICATION on [Date]

Drug	Dose	Route	Frequency	Drug	Dose	Route	Frequency

RESCUE MEDICATION

PROFESSIONAL CONTACT DETAILS

	Name	Contact Number
Hospital Ward		
Paediatrician – Hospital GMC No		
Community Paediatrician GMC No		
GP		
Community Nursing		
Palliative Care Nurse		
Other (specialists)		

COPIES (please tick if provided with copy of Emergency Care Plan)

Patient (eg wheelchair)	☐	Parents[PR]	☐	School	☐
Respite Unit	☐	NIAS	☐	Emergency Department	☐
Ward	☐	CCN	☐	GP	☐

Please note this plan can be reviewed/changed at any time following discussion with child or those with parental responsibility