# SOUTHERN HIGHLANDS COMMUNITY MENTAL HEALTH CENTER

## PASSENGER PROFILE SHEET
**(Must be accompanied by picture)**

**NAME:** _____ **SS#:** _____/_____/_____ **BIRTHDATE:** _____

**RESIDES AT:** _____

**MAILING ADDRESS:** _____

**PSYCHIATRIST:** _____ **PSYCHIATRIC DIAGNOSIS:** _____

**CASE MANAGER:** _____ **NEXT OF KIN:** _____ **PHONE:** _____

**ALLERGIES:** _____

**HEIGHT:** _____ **WEIGHT:** _____ **PICTURE:** ☐ **Yes** ☐ **No**

**EMERGENCY CONTACT:** _____ **PHONE:** _____

**IS THIS PERSON AMBULATORY?** _____ **Yes** _____ **No**

**IF AMBULATION ASSISTIVE DEVICES ARE USED, LIST:**

_____

**CHECK ALL THAT APPLY: (Copy must be attached)**

_____ **DO NOT RESUSCITATE ORDER** _____ **LIVING WILL** _____ **ADVANCE DIRECTIVES**

**MEDICAL POWER OF ATTORNEY:** _____/_____
**NAME** **PHONE**

**GUARDIAN:** _____ **PHONE :**_____

**INSURANCE NAME:** _____**POLICY #:** _____

**OTHER CRITICAL INFORMATION**_____

_____

_____ _____
**SIGNATURE OF PERSON COMPLETING FORM** **DATE**