

EMERGENCY INFORMATION

Name: _____

Address: _____

City/State/Zip: _____

Phone: _____

Emergency contact information:

Call first: _____

Call second: _____

Please carry a separate list* if more space is needed.
*Check box if you have a separate list:

Drug/dose	Times taken (be specific)

American Parkinson Disease Association Information and Referral Center
 Phone: 866.250.2414 Fax: 650.725.7459
 www.parkinsons.stanford.edu



Re: _____
 DOB: _____

Dear Health Care Provider,
 My Patient, _____ has Parkinson's disease.
 He/she takes medications on a carefully timed schedule. This schedule has been developed to give him/her the best function and fewest possible side effects. If you are caring for him/her in the hospital ER or as an inpatient, please make every attempt to maintain the established schedule as much as possible. It can mean the difference between my patient being able to speak, swallow safely, or move and otherwise function independently or needing help.
 I will be happy to discuss any questions you may have related to my patient or these medications. I can be reached at _____.

Sincerely,

My PD doctor is (contact info):

My primary doctor is (contact info):