

LIFELINE SUBSCRIBER INFORMATION SHEET/APPLICATION
ST NICHOLAS HOSPITAL
3100 SUPERIOR AVENUE
SHEBOYGAN WI 53801-9988
Phone (920) 451-8365 Fax (920) 457-5951
www.stnicholashospital.org

Type of Unit: Landline _____ Wireless _____
Type of Button: Personal Help (PHB) _____ Auto Alert (AAB) _____ Mobile Help (MHB) _____

Please **PRINT** the following information and return this form to the LIFELINE office.

Name _____ Age _____ Date of Birth _____

Address _____ City / Zip _____

Phone () _____

Physician's Name _____ Phone () _____
(FIRST/LAST)

Hospital Preference _____ Phone () _____

Which county do you live in? _____

Which township / village / municipality, etc. do you live in: _____

Do you have a household key hidden / If yes, where? _____

Drug Allergies _____

Do you wear a pacemaker? ___ Yes ___ No

Briefly explain any medical problems – diabetic, arthritis, heart problems, stroke, etc.

Directions to your home: _____

TELEPHONE & ELECTRICAL INFORMATION

1. How close is the nearest electrical outlet to your telephone jack? _____

2. Is the above electrical outlet controlled by a wall switch or do you use an electrical bar or extension cord on it? _____

3. What kind of "on-line" service do you use (e.g. Dial-up, cable, DSL)? _____

4. The Name of your Phone Company _____

RESPONDERS:

Who do you (the subscriber) want to check on you in case you need assistance?
Consider family, neighbors or friends who live **NO MORE THAN 10 TO 15**

MINUTES FROM YOU. THEY MUST HAVE A KEY TO YOUR HOME.

1. Name _____ Home Phone () _____
Address _____ Cell Phone () _____
City/Zip _____ Work Phone () _____
Relationship _____ Key: Yes No

2. Name _____ Home Phone () _____
Address _____ Cell Phone () _____
City/Zip _____ Work Phone () _____
Relationship _____ Key: Yes No

3. Name _____ Home Phone () _____
Address _____ Cell Phone () _____
City/Zip _____ Work Phone () _____
Relationship _____ Key: Yes No

NOTIFY:

Who would you (the subscriber) like to be notified that you received assistance from Lifeline? This can be the Responders previously listed, or anyone living in the United States. They would also be notified if you are transported to the hospital.

Name _____ Home Phone () _____
Address _____ Cell Phone () _____
City/State/Zip _____ Work Phone () _____
Relationship _____

OTHER INFORMATION

1. This form was completed by: _____
2. Person to contact to set up installation appointment: Name _____
Phone () _____
3. Who to contact with billing questions for Lifeline: Patient Other (fill out below)
Name: _____ Phone No _____
4. Do you have a Power of Attorney? YES _____ NO _____
5. If yes, please complete below:
Name _____
Address _____
Relationship _____