Emergency Recovery Information

Keep all your important information and contacts in one place so you are prepared to begin recovery after a disaster or emergency. It’s important that you update this document annually so the information is current. Be sure to include relevant information for each family member and print additional pages if needed. Find this document and more disaster and emergency preparedness resources at on.cff.org/DisasterandEmergencyPreparedness. For disaster or emergency-related issues, please email the dedicated disaster response team at cdt@cff.org. For all other matters, contact compass@cff.org.

FAMILY INFORMATION

Name:
Relationship:
Phone Number:
Important Medical Information/Other:

Name:
Relationship:
Phone Number:
Important Medical Information/Other:

Name:
Relationship:
Phone Number:
Important Medical Information/Other:

Name:
Relationship:
Phone Number:
Important Medical Information/Other:

Name:
Relationship:
Phone Number:
Important Medical Information/Other:
EMERGENCY CONTACT INFORMATION

Name: 
Relationship: 
Phone Number: 

Name: 
Relationship: 
Phone Number: 

Name: 
Relationship: 
Phone Number: 

Name: 
Relationship: 
Phone Number: 

MEDICAL CONTACT INFORMATION

Retail pharmacy: 
Address: 
Phone Number: 
Fax Number: 
Email: 

Specialty Pharmacy: 
Address: 
Phone Number: 
Fax Number: 
Email: 

Mail Order Pharmacy: 
Address: 
Phone Number: 
Fax Number: 
Email: 

Durable Medical Equipment Company: 
Address: 
Phone Number: 
Fax Number: 
Email: 

cff.org/Compass 844-COMPASS cdt@cff.org
Cystic Fibrosis Care Center:
Address:
Phone Number:
Fax Number:
Email:

Primary Care Physician:
Address:
Phone Number:
Fax Number:
Email:

Specialist:
Address:
Phone Number:
Fax Number:
Email:

Specialist:
Address:
Phone Number:
Fax Number:
Email:

Specialist:
Address:
Phone Number:
Fax Number:
Email:

Specialist:
Address:
Phone Number:
Fax Number:
Email:

Dentist:
Phone Number:
Email:
INSURANCE CONTACT INFORMATION

Medical Insurance:
Member ID:
Group #:
Bin/Rx #:
Member Services/Customer Service Number:
Address:
Email:

Medical Insurance:
Member ID:
Group #:
Bin/Rx #:
Member Services/Customer Service Number:
Address:
Email:

Car Insurance:
Policy Number:
Member Services/Customer Service Number:
Address:
Email:

Home or Renters Insurance:
Member Policy Number:
Member Services/Customer Service Number:
Address:
Email:
<table>
<thead>
<tr>
<th>Medication</th>
<th>Dose</th>
<th>Schedule</th>
<th>Prescribing Doctor</th>
<th>Pharmacy</th>
<th>Notes (Example: requires refrigeration, family member):</th>
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</tbody>
</table>

**TREATMENT INFORMATION**
Medication:
Dose:
Schedule:
Prescribing Doctor:
Pharmacy:
Notes:

Medication:
Dose:
Schedule:
Prescribing Doctor:
Pharmacy:
Notes:

Device:
Prescribing Doctor:
Manufacturer Customer Service Number:
Notes:

Device:
Prescribing Doctor:
Manufacturer Customer Service Number:
Notes:

Medical Supplies:
Prescribing Doctor:
Customer Service Number:
Notes: