Creekview Assessment Center

Neuro/Psychological Testing

300 Creek View Road, St 101 B
Newark, DE 19711

Emergency Contact Form:

This information will be extremely important in the event of an accident or medical emergency.
Please be sure to sign and date this form. Thank you!

Client's name:_____Date of birth: _____

Your name (if patient is child): _____ Relationship to Child: _____

Primary Emergency Contact

Name:_____Phone number: _____

Relationship: _____

Secondary Emergency Contact

Name:_____Phone number: _____

Relationship: _____

Comments (include any special medical or personal information you would want an emergency care provider to know – or special contact information):

I,_____, have voluntarily provided the above contact information and authorize **Creekview Assessment Center, PA** and its staff to contact any of the above on behalf of myself (or my child) in the event of an emergency.

Print Client Name: _____
Signature: _____
Signature Date: _____
Relationship to Client (if client unable to sign): _____
