PHILIPS Lifeline

Exhibit 3: GoSafe CarePlan

Program Name	XC Code	Subscriber Serial #	Install Date: *(mm/dd/yy)*	☐ Multiple Service ☐ 2nd Subscriber ☐ Current Subscriber

Subscriber #1 Information

Salutation	Subscriber First Name	Subscriber Last Name	
Residential Street Address		Apt. No.	PO Box
City	Province	Postal Code	Cross Street
Home Phone #	Cell#	Alternative #	

Subscriber #1 Information

Salutation	Subscriber First Name	Subscriber Last Name	Relation

Responder # 1

First Name Last Name E-mail Address	**Type of Responder** (Check all that apply) ☐ **Main Responder** ☐ **Primary NOK** ☐ **NOK** ☐ **Person to Notify (PTN)** ☐ **Primary Mobile Responder**	**Communication Preference** (complete only if Primary NOK/NOK) ☐ **E-mail** ☐ **SMS text messages**

Relation (With the subscriber)	☐ English ☐ French ☐ Other (Specify): _____	☐ Has Key	Minutes Away	Hours of Work

Home Phone #	Cell Phone #	Business Phone #	Extension #

Responder # 2

First Name Last Name E-mail Address	**Type of Responder** (Check all that apply) ☐ **Main Responder** ☐ **Primary NOK** ☐ **NOK** ☐ **Person to Notify (PTN)** ☐ **Primary Mobile Responder**	**Communication Preference** (complete only if Primary NOK/NOK) ☐ **E-mail** ☐ **SMS text messages**

Relation (With the subscriber)	☐ English ☐ French ☐ Other (Specify): _____	☐ Has Key	Minutes Away	Hours of Work

Home Phone #	Cell Phone #	Business Phone #	Extension #

Responder # 3

First Name Last Name E-mail Address	**Type of Responder** (Check all that apply) ☐ **Main Responder** ☐ **Primary NOK** ☐ **NOK** ☐ **Person to Notify (PTN)** ☐ **Primary Mobile Responder**	**Communication Preference** (complete only if Primary NOK/NOK) ☐ **E-mail** ☐ **SMS text messages**

Relation (With the subscriber)	☐ English ☐ French ☐ Other (Specify): _____	☐ Has Key	Minutes Away	Hours of Work

Home Phone #	Cell Phone #	Business Phone #	Extension #

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Subscriber #1 First Name	Subscriber #1 Last Name	Subscriber #1 Home Tel. No.

Medical Information

Date of Birth (mm/dd/yyyy)	Gender: ☐ Male ☐ Female	Language: (other than English) ☐ French ☐ Other-Please specify	
Physical Description	Height:	Weight:	Ethnicity:
	Hair Color:	Eye Color:	Race:
Special Needs	☐ Walker ☐ Cane ☐ Wheelchair ☐ Hearing Aid ☐ Eyeglasses ☐ Other ***Pacemaker not allowed to be used with Mobile Help Button**		
Medication Location *(Ex: Kitchen counter)*			
Medical History (*Ex: Stroke (Nov 2014)*)	*(Only information important for EMS)*		

Medical Conditions

- ☐ ALS
- ☐ Alzheimer's
- ☐ Angina
- ☐ Arthritis
- ☐ Asthma
- ☐ COPD
- ☐ Cancer
- ☐ Cerebral Palsy
- ☐ Cirrhosis
- ☐ Congestive Heart Failure
- ☐ Crohn's Disease
- ☐ Dementia
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Hearing Impaired
- ☐ Other
- ☐ Heart Disease
- ☐ Heart Valve Implant
- ☐ Hemophilia
- ☐ High Blood Pressure
- ☐ Kidney
- ☐ Leukemia
- ☐ Limited Mobility
- ☐ Lupus
- ☐ Multiple Sclerosis
- ☐ Muscular Dystrophy
- ☐ Osteoporosis
- ☐ Parkinson's Disease
- ☐ Quadriplegic
- ☐ Stroke
- ☐ Visually Impaired

Medications

- ☐ Anticoagulants (eg. Coumadin)
- ☐ ASA
- ☐ Blood Pressure Med
- ☐ Dialysis
- ☐ Heart Medication (eg. Digoxin, Nitro)
- ☐ Insulin
- ☐ Oxygen
- ☐ Other

Allergies

Allergies: ☐ Yes ☐ No

- ☐ Adhesive Tape
- ☐ Amoxicillin
- ☐ Ampicillin
- ☐ Aspirin
- ☐ Bee Sting
- ☐ Codeine
- ☐ Dairy Products
- ☐ Erythromycin
- ☐ Morphine
- ☐ Naproxen
- ☐ Peanuts
- ☐ Penicillin
- ☐ Sulfa Drugs
- ☐ Tetracycline
- ☐ Other

Site Optional Information

Special Services Request/Notes ☐ Language: (other than English)			
Preferred Name	Last Name Sounds Like:		
Directions to Home			
Entry Code/Buzzer	Hidden Key/Lockbox Location		
Lockbox Code	☐ Lifeline Provided ☐ Customer Owned	Location of Lifeline Unit	
Location of Voice Ext.	No. of phone rings	Phone Provider	Type of Pet/Name

Emergency Phone Numbers *(Do not list 911 or 1-800s) ***For home location only*

Ambulance	Police	Fire

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Subscriber #1 First Name	Subscriber #1 Last Name	Subscriber #1 Home Tel. No.

1. Frequently Visited Contact

First / Last Name		Location Name	
Location Street Address			Suite/Apt. No.
City	Province	Postal Code	Cross Street
Phone #	Special Services Requests / Notes		

2. Frequently Visited Contact

First / Last Name		Location Name	
Location Street Address			Suite/Apt. No.
City	Province	Postal Code	Cross Street
Phone #	Special Services Requests / Notes		

Subscriber #1 Vehicle Information

Vehicle Colour	Vehicle Make/Model	Vehicle License Plate

Equipment

Base Model/Type: ☐ 7000L ☐ 7000C ("**WC**")	**Serial No.:**
Subscriber Mobile Help Button: Assigned To Subscriber #1: ☒ 7000MHB	**Serial No.:**

Additional Services

☐ Check in Calls ☐ Lifeline Lock Box ☐ Philips Medication Dispenser

Subscriber #1 understands, agrees and acknowledges that: (a) the information provided on the CarePlan is accurate and complete as of the date indicated below; (b) the CarePlan forms an integral part of, and is subject to the terms of the Agreement entered into between Subscriber #1 and Program.

Subscriber #1 Signature _____ Date _____

Response Centre Contact Information

105-95 Barber Greene Rd, Toronto ON M3C 3E9 *Tel:* 1-800-387-1215 or (416) 445-1643 *Fax:* 1-800-972-1189 or (416) 445-1208

100-774 Decarie Blvd, Saint-Laurent QC H4L 3L5 *Tel.:* 1-877-387-1215 or (514) 735-7102 *Fax:* 1-800-972-1189 *(DQ)* or 1-800-472-7118 (General)