Gallbladder Surgery Emergency Contact Information

Date: [Insert Date]

Patient Name: [Insert Patient's Name]

Patient ID: [Insert Patient ID]

Emergency Contact Details

Name: [Insert Emergency Contact Name]

Relationship to Patient: [Insert Relationship]

Phone Number: [Insert Phone Number]

Email: [Insert Email Address]

Additional Information

Preferred Hospital: [Insert Hospital Name]

Primary Care Physician: [Insert Physician's Name and Contact Details]

Instructions

In case of an emergency, please contact the above emergency contact or take the patient to the preferred hospital listed above.

Thank you for your attention to this important information.