

INITIAL CHANGE

OKALOOSA COUNTY SPECIAL NEEDS PATIENT REGISTRATION FORM

To be completed by OCHD:
SpNS Eligible
 Yes No

PLEASE PRINT

Last Name, First Name: _____ MI: _____ Speak English? ____ Yes ____ No

Street Address: _____ City: _____ Zip Code: _____ Home Phone: _____

TDD/TDY: Y N Social Sec. #: _____ - _____ - _____ DOB: ____/____/____ Age: _____ Sex: _____

Directions to home: _____

Next of Kin Name: _____ Home Phone: _____ Relationship: _____

Emergency Contact Name: _____ Home Phone: _____ Relationship: _____

Doctor's Name: _____ Phone: _____

Home Health Care Agency: _____ Oxygen Supplier: _____

Please List Main Illness (DO NOT LEAVE BLANK):

LIVING SITUATION	IMPAIRMENT	IMPAIRMENT	DISASTER PLAN
<p>(Check all that apply)</p> <input type="checkbox"/> Mobile Home/Trailer <input type="checkbox"/> Dependent on Electricity <input type="checkbox"/> Emergency Alert Equipment <input type="checkbox"/> Life Sustaining Medications <input type="checkbox"/> No Alternate Housing <input type="checkbox"/> No Emergency Heat <input type="checkbox"/> No Telephone <input type="checkbox"/> Lives Alone <input type="checkbox"/> Lives with Spouse <input type="checkbox"/> Lives with Spouse & Children <input type="checkbox"/> Lives with Children <input type="checkbox"/> Lives with Parents <input type="checkbox"/> Lives with Other Relative <input type="checkbox"/> Lives with Non-Relative <input type="checkbox"/> Lives in Group Home <input type="checkbox"/> Other: _____ _____ <input type="checkbox"/> Lives in River Flood Zone <input type="checkbox"/> Lives in Hurricane Evacuation Zone	<p>(Check All That Apply)</p> <input type="checkbox"/> Mobility <input type="checkbox"/> Walker <input type="checkbox"/> Wheelchair <input type="checkbox"/> Bedridden <input type="checkbox"/> Memory <input type="checkbox"/> Vision <input type="checkbox"/> Hearing <input type="checkbox"/> Speech <input type="checkbox"/> Mental <input type="checkbox"/> Functions independently <input type="checkbox"/> Mild confusion <input type="checkbox"/> Totally dependent <input type="checkbox"/> Anxiety/Depression <input type="checkbox"/> Epilepsy <input type="checkbox"/> Controlled with medications <input type="checkbox"/> Uncontrolled <input type="checkbox"/> Cardiac History <input type="checkbox"/> Controlled with medications <input type="checkbox"/> Incontinent of Bowel/Bladder <input type="checkbox"/> G or NG Tube Feeding <input type="checkbox"/> Home IV Therapy <input type="checkbox"/> Insulin Dependent	<p>(Check and list all that apply)</p> <input type="checkbox"/> Dialysis Dependent <input type="checkbox"/> Respirator Dependent <input type="checkbox"/> Oxygen Dependent _____ LPM <input type="checkbox"/> Nebulizer Use <input type="checkbox"/> Requires assistance with Activities of Daily Living: _____ _____ <input type="checkbox"/> Requires monitoring of vital signs or medications: _____ _____ <input type="checkbox"/> Requires routine nursing assistance: _____ _____ <input type="checkbox"/> Allergies: _____ _____	<p>DISASTER PLAN</p> <input type="checkbox"/> Staying at Home <input type="checkbox"/> To Any Shelter <input type="checkbox"/> To Special Needs Shelter (Caregiver _____) <input type="checkbox"/> Other (Family, Hotel, Hospital) <input type="checkbox"/> Needs Evacuation Transport By: <input type="checkbox"/> Standard Vehicle <input type="checkbox"/> Ambulance <input type="checkbox"/> Lift Gate <input type="checkbox"/> Guide Dog <input type="checkbox"/> Vial of Life User <input type="checkbox"/> Other: _____ <p>OTHER CONCERNS:</p> <input type="checkbox"/> Do Not Resuscitate Order (DNRO) Location: _____ <input type="checkbox"/> Living Will Location: _____ <input type="checkbox"/> Patient has Pets: <input type="checkbox"/> Dog <input type="checkbox"/> Cat <input type="checkbox"/> Other: _____

I, the undersigned, give permission to release the information above to the Emergency Management Office for assistance with evacuation in the event of a Natural Disaster/Emergency. I also give Emergency Service Providers, whether paid or volunteer, permission to enter my home in case of a declared emergency.

Patient Signature: _____ Date: _____ Witness: _____

Agency Name: _____ Phone: _____ Person Completing Form: _____

Additional Comments: _____

**Please return form to: Okaloosa County Emergency Management, 6 11th Avenue, Shalimar, FL 32579
Fax: (850) 651- 7170 Phone: (850) 651-7560**

FOR USE BY AGENCY SUBMITTING ONLY: DELETION CODES (check one to remove from registration):
 MOVED DISCHARGED DECEASED NO LONGER NEEDS ASSISTANCE