ORANGE COUNTY HEALTH SERVICES DEPARTMENT
PEOPLE WITH SPECIAL NEEDS PROGRAM
REGISTRATION FORM

Personal Information for Individual with Special Needs

First Name _____ Last Name _____

Home Address _____ Apt/Lot No. _____ City _____ State _____ Zip Code _____

Residence Type: ⬭ Single Family Home ⬭ Mobile Home ⬭ Multi-Family Home ⬭ Apartment ⬭ Other_____

Name of Subdivision/Condo/Mobile Home/Apartment Complex _____

Primary Phone ( ) _____ ⬭ Primary Phone is TTY/TTD Secondary Phone ( ) _____

⬭ I Do Not Have A Phone Email Address: _____

Date of Birth:_____ Gender: ⬭ Male ⬭ Female Height:_____Ft_____In

⬭ Transgender ⬭ Non-Binary

Primary Language _____ ⬭ Prefer Not to Answer Weight: _____ lbs.

Mailing Address (Please enter if Different than your Physical Address) ⬭ Same as Physical Address

Mailing Address _____ Apt/Lot No. _____ City _____ State _____ Zip_____

Emergency Contact(s) Information:

Primary Contact

First Name _____ Last Name _____ Relationship:_____

Primary Phone ( ) _____ Secondary Phone ( ) _____ ☐ Checking this box allows medical information to be shared with this contact.

Secondary Contact

First Name _____ Last Name _____ Relationship:_____

Primary Phone ( ) _____ Secondary Phone ( ) _____ ☐ Checking this box allows medical information to be shared with this contact.

Caregiver and Family Information

Caregiver Name:_____ Caregiver's Phone:_____

Do you require a 24 hour caregiver? ◯ Yes ◯ No Will your caregiver travel and/or stay with you? ◯ Yes ◯ No

Medical Providers:

Physician's Name_____ Physician's Phone: _____

Pharmacy Name_____ Pharmacy Phone: _____

Home Health Care Agency Name_____ Home Health Care Agency Phone: _____

Medical Equipment Provider Name_____ Medical Equipment Provider Phone: _____

Oxygen Provider Name:_____ Oxygen Provider Phone:_____

Transportation Needs:

If transportation assistance is required, please check all vehicle types that can be used for transportation.

◯ Car ◯ Bus ◯ Van ◯ Ambulance ◯ Stretcher

Do you require continous Oxygen During Transport? ◯ Yes ◯ No

How many family members (<u>who live in your home</u>) will accompany you if you choose to seek shelter? _____

Mobility Needs:

Do you have mobility needs? ◯ Yes ◯ No

◯ Confined to Bed ◯ Paralyzed ◯ Wheelchair ◯ Attendant to Assist in Ambulating

◯ Partial Paralysis

◯ Complete Paralysis

Select all devices that are used to aid mobility: ◯ Walker / Cane ◯ Standard Wheelchair ◯ Motorized Wheelchair ◯ Motorized Scooter

Equipment Needs:

Are you dependent on Electrical Equipment? ◯ Yes ◯ No

Are you Oxygen Dependent? ◯ Yes ◯ No

Oxygen Type	Oxygen Mode	Liter Flow	Frequency
◯ Gasseous	◯ Mask	_____	◯ 24 Hours
◯ Liquid	◯ Nasal Cannula		◯ Only Overnight
	◯ Trach Collar	_____	◯ As Needed

Select All Equipment Used:

◯ Apnea Monitor ◯ CPAP / BIPAP ◯ Cardiac Monitor ◯ Dialysis Catheter ◯ Feeding Pump

◯ Feeding ◯ Nebulizer ◯ Oxygen Concentrator ◯ Suction Pump ◯ Ventilator

◯ Wound Vac ◯ Medications that Require Refrigeration ◯ Hoyer Lift ◯ Pulse Oximeter ◯ Catheter

◯ Tracheostomy Tube ◯ Other Equipment _____

○ Alzheimer Disease _____Mild _____Severe	○ ALS ____Early Stage ____Middle Stage ____Late Stage	○ Aphasia	○ Assistance with Daily Living	○ Asthma	○ Arthritis
○ Autism	○ Behavioral Health	○ Blind/ Low Vision/ Vision Impaired	○ Cancer ___Chemotherapy ____Radiation ____Surgical ____Palliative ____Remission _____End Stage	○ Cardiac ____Stable ____Unstable	○ Cerebral Palsy
○ COPD	○ Comatose	○ Contagious Disease	○ Cystic Fibrosis	○ Deaf/ Hard of Hearing	○ Dementia _____Mild ____Moderate ____Severe
○ Diabetes _____Insulin Dependent ____Non-Insulin Dependent	○ Dialysis ____At Facility ____At Home ____Peritoneal Frequency ____2 times week ____3 times week	○ Eating and Swallowing Disorder	○ Edema	○ Emphysema	○ Fractured Bones
○ Frail Elderly	○ High Blood Pressure	○ Hip/Knee Replacement ____Non-Ambulatory ____Confined to Bed	○ Incontinence	○ IV Care	○ Mentally/ Memory Impaired
○ Multiple Sclerosis	○ Muscular Dystrophy	○ Neuromuscular Disorder	○ Ostomy	○ Paralysis	○ Parkinson's Disease
○ Seizures	○ Sleep Apnea/ CPAP User	○ Speech Impediment	○ Stroke	○ Terminal Endstage	○ Wounds/ Sores/Rashes
○ Other					

Service Animals / Pets

Do you own an animal? ⬭ Yes ⬭ No What type of animal? ⬭ Dog ⬭ Cat ⬭ Miniature Horse ⬭ Other_____

Is this animal a service animal (eg. a seeing eye dog)? ⬭ Yes ⬭ No Is this animal an emotional support animal? ⬭ Yes ⬭ No

Animal's Name _____ Breed/Description: _____ Weight _____

Is there a carrier cage available? ⬭ Yes ⬭ No Is there a leash available? ⬭ Yes ⬭ No Is there a muzzle available? ⬭ Yes ⬭ No

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Animal's Name _____ Breed/Description: _____ Weight _____

Is there a carrier cage available? ⬭ Yes ⬭ No Is there a leash available? ⬭ Yes ⬭ No Is there a muzzle available? ⬭ Yes ⬭ No

Additional animals/pets should be listed in Comments.

Additional Comments / Information

Please enter any additional information that may be useful for our emergency personnel to evacuate this person.

Acknowledgement

The following statements provide information on how Orange County handles Personal Health Information (PHI). They will not impact the receipt of services during time of hurricanes or disasters.

It is crucial to our response efforts that the information you provide be as accurate and up to date as is possible. You will be contacted periodically to verify and ensure the information provided is correct and to make any necessary changes. Individual forms will need to be updated on an annual basis to remain active on the registry.

Your information will only be released to emergency response agencies for assistance during emergency and disaster situations; and emergency responders may enter your home and provide for your needs in an emergency situation.

Expenses associated for transport or admission to a hospital while in a shelter setting will be the client's responsibility.

This form was completed by:

☐ Special Needs Client: Client Signature _____ Date _____

☐ Family Member: Name:_____ Phone No._____

☐ Case/Social Worker: Name:_____ Phone No._____

☐ Health Care Proxy: Name:_____ Phone No._____

☐ Other: Name:_____ Phone No._____

Return Completed Forms to:
Orange Co Special Needs Program
2002-A E. Michigan Street
Orlando, FL 32806
FAX: (407) 836-2838