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 (who live in your home) 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<br>_____Mild<br>_____Severe | ○ ALS<br>____Early Stage<br>____Middle Stage<br>____Late Stage | ○ Aphasia | ○ Assistance with Daily Living | ○ Asthma | ○ Arthritis |
| ○ Autism | ○ Behavioral Health | ○ Blind/ Low Vision/ Vision Impaired | ○ Cancer<br>___Chemotherapy<br>____Radiation<br>____Surgical<br>____Palliative<br>____Remission<br>_____End Stage | ○ Cardiac<br>____Stable<br>____Unstable | ○ Cerebral Palsy |
| ○ COPD | ○ Comatose | ○ Contagious Disease | ○ Cystic Fibrosis | ○ Deaf/ Hard of Hearing | ○ Dementia<br>______Mild<br>____Moderate<br>____Severe |
| ○ Diabetes<br>_______Insulin Dependent<br>____Non-Insulin Dependent | ○ Dialysis<br>____At Facility<br>____At Home<br>____Peritoneal<br>Frequency<br>____2 times week<br>____3 times week | ○ Eating and Swallowing Disorder | ○ Edema | ○ Emphysema | ○ Fractured Bones |
| ○ Frail Elderly | ○ High Blood Pressure | ○ Hip/Knee Replacement<br>____Non-Ambulatory<br>____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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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

*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**



Updated 3/2020