

SAMPLE EMERGENCY EVACUATION/SPECIAL NEEDS QUESTIONNAIRE

PERSONAL INFORMATION:

Name: _____ Spouse: _____

Home Address: _____ Apt. No.: _____

Mailing Address: _____

City: _____ Zip Code: _____ Phone: _____

Age: _____ Date of Birth: _____ Sex Male Female

Residence Type: Private Home Apt/Condo Mobile Home

Name of Complex/Subdivision: _____

Yearly Resident? Yes No If no, from: _____ to: _____

Type of Medical Disability: _____

Are you a Hospice Patient? Yes No

(If yes, include a copy of your physician's "No-Code" with this form.)

EVACUATION INFORMATION:

Type of Shelter requested: Standard Special Needs

Do you: Care for Yourself Have Caretaker Need Assistance

Name of Caretaker: _____ Phone #: _____

Are you ambulatory With Without assistance?

Please answer the following: YES NO SOMETIMES

Are you confined to a bed?

Do you use a Wheelchair?

Do you use a Walker or Cane?

Do you require a special diet?

If yes, what type _____

Are you on a life-support system requiring electricity? Yes No

If yes, which type? Oxygen Respirator

If you use oxygen, how many hours do you use it per day? _____

Do you have a portable oxygen tank? Yes No

Are you on any Medication(s)? Yes No

If yes, what kind? _____

Are you allergic to any medication(s)? Yes No Type:

Name of Your Physician _____ Phone # _____

Eligibility for the Special Needs Shelter: (Please check any item applicable)

- Oxygen Therapy
- Life Support equipment
- 'Ostomy management
- Indwelling catheter(s)
- Bedridden
- Heavy Medication Use
- Injectable medications (shots) or IV Therapy
- Frequent dressing changes (at least daily)
- Dependent on others for care and assistance
- Terminally Ill
- Unstable medical condition; needs regular nursing or monitoring (please specify)
- Other _____

Please list the types of disposable medical supplies you use on a daily / weekly basis:
(please circle one)

Do you have any other comments or suggestions that may assist us in your care during an evacuation?

Nearest Relative or Friend to contact in the case of an emergency:

Name: _____ Phone #: _____

The undersigned patient grants permission for Indian River County to release this information to emergency response agencies.

Signature

Date

Please return this form to: