# WASHINGTON COUNTY OFFICE OF EMERGENCY MANAGEMENT

| Date | SPECIAL NEEDS REGISTRY FORM | Client ID |
|---|---|---|
| | | |

Mississippi and Federal law requires that information contained in your medical records be held in strict confidence and not be released without your written consent. The consent you sign on this page will remain in effect until you request in writing that your consent be withdrawn, which you may do at any time. You have a right to request and obtain a copy of this consent. This form is intended for Special Needs Registration purposes only. Dissemination, distribution, or copying of this form is strictly prohibited except for use by authorized persons. The original of this form shall be secured in a locked file.

| Home Health Agency | Medical Equipment Supply Co. | Dialysis Center |
|---|---|---|
| | | |

**Other Agency Affiliations** (i.e., Children's Medical Services; Hearing, Visual, Developmental, Mental Health Services; Other Special Services)

## PERSONAL INFORMATION

| Last Name | First Name | MI | Last 4 of Social Security # | Birthdate (Mo/Day/Yr) | Sex |
|---|---|---|---|---|---|
| | | | __ __ __ __ | __ __/ /__ __ __ __ | ☐ M ☐ F |

**Ethnic Group**

☐ African/American (B)
☐ Caucasian (W)
☐ Hispanic (H)
☐ Asian or Pacific Islander (AS)
☐ American Indian or Alaskan Native (AI/AN)
☐ Native Hawaiian/Other Pacific Islander (NH/PI)
☐ Black & White (B&W)
☐ American Indian or Alaskan Native & White (AI/AN&W)
☐ American Indian or Alaskan Native & Black (AI/AN&B)
☐ Asian or Pacific Islander and White (AS&W)
☐ 2+Races Non-Hispanic (2+NH)

| Street Address | City | Zip | In City Limit ☐ Yes ☐ No<br>Mobile Home ☐ Yes ☐ No |
|---|---|---|---|
| Mailing Address (if different) | City | Zip | Flood Prone ☐ Yes ☐ No<br>Phone #s (Include Area Code) |
| Name of Subdivision, MH Park, Apt Bldg., etc. | If address is temporary, give dates:<br>From: To: | | Home: _ _ _-_ _ _-_ _ _ _<br>Cell: _ _ _-_ _ _-_ _ _ _ |

**Email Address:**

**Living Situation** ☐ Lives Alone ☐ With Spouse ☐ With Children ☐ With Parents ☐ Other _

## MEDICAL INFORMATION (*Check and complete those that apply to your medical condition.*)

☐ Required or Life-Sustaining Medical Equipment
- ☐ Oxygen Concentrator
- ☐ Respirator(*Ventilator*)
- ☐ Portable Oxygen
- ☐ Suction Machine
- ☐ Nebulizer
- ☐ Other _

☐ Oxygen - Continuous Amount of Oxygen? _

☐ Oxygen - Treatments Only
Amount of Oxygen? How Often? _

☐ Oxygen - PRN (*As Needed*)
Nighttime-# of hours?
Daytime-# of hours?
Amount used per day? _

☐ Cardiac History
☐ Dialysis How Often? _
☐ Incontinent
☐ Life-Sustaining Medications (*if checked, attach list*)
☐ Frail
☐ Mobility Impaired (*Explain*) _
☐ Wheelchair ☐ Walker ☐ Cane

☐ Wheelchair Bound
☐ Bedridden
☐ Weight > 300 lbs.
☐ Hearing Impaired
☐ Sight Impaired
☐ Speech Impaired
☐ Memory Impaired
☐ Anxiety/Depression
☐ Emergency Alert Equipment
☐ DNR Order (*if checked, attach copy*)
☐ Mental Health Impaired (*Explain*)

☐ Special Dietary Needs (*Explain*)

☐ Allergies (*List*)

☐ Other (*Explain*)

| Primary Diagnosis: | Secondary Diagnosis: | If disability is temporary, give dates:<br>From: To: |
|---|---|---|
| | | |

| Emergency Management Use Only | Health Department Use Only |
|---|---|
| Previous Application: ☐Yes ☐No<br>If yes, current status: | ☐ SN Cat 1(*SN Shelter*) ☐ SN Cat 2(*Hospital*) ☐ SN Cat 3(*Registry Only*)<br>☐ Need More Information Initials: |

## EMERGENCY CONTACT INFORMATION:

| First Name: | Last Name: | Relationship: | Phone: |
|---|---|---|---|
| First Name: | Last Name: | Relationship: | Phone: |

## PHYSICIAN/PHARMACY INFORMATION:

| Physician's Last Name: | First Name: | Phone: |
|---|---|---|
| Pharmacy Name: | | Phone: |

## SHELTER INFORMATION:

Will you provide your own transportation to the shelter? ☐ Yes ☐ No

If you need assistance with transportation, check one of the types of transportation you need:

☐ automobile
☐ van w/wheelchair lift
☐ stretcher

## PET INFORMATION:

If pets will be accompanying you to the shelter, check the appropriate box and indicate how many.

☐ Cat _
☐ Dog _
☐ Guide Dog _
☐ Other (*Explain* )_

| Name of person going with client to the shelter: | Phone: |
|---|---|

## COMMENTS:

## AUTHORIZATION INFORMATION:

OPTIONAL: PREAUTHORIZATION TO ENTER HOME BY EMERGENCY PERSONNEL

I authorize emergency response personnel and volunteers working under the direction of these agencies to enter my home during search and rescue operations following a disaster, if necessary, to assure my safety and welfare.

Authorized Signature:

I, (*Print Name* )
understand that all of my medical records are confidential, exempt from the public records law, and not to be disclosed to anyone without my consent or that of my guardian pursuant to section Miss. Code Ann. § 41-91-11.

I hereby provide my consent for the members of the Washington County Emergency Management Office to have access to them medical information contained in this form.

I understand that this form is not a reservation for the Special Needs Shelter but that my medical information will be utilized to determine/assess plans appropriate for my care and treatment during an emergency.

I further understand that only those persons who have a need to know this information, will have access to it. **It is your responsibility to verify your contact information with the Washington County Office of Emergency Management at least annually. If we are unable to reach you, you will be removed from the Special Needs Registry. **

Authorized Signature: Date:

| Print Name of Person Completing This Form If Other Than Client: | Phone: |
|---|---|

*Mail form to: Washington County Office of Emergency Management: 910 Courthouse Lane, Suite B, Greenville MS 38701*
*Phone: 662-335-1945 rev. 1-20-2016*