Form 7 - State Medical Needs Shelter Registration Form

TO BE COMPLETED BY THE RESIDENT/CAREGIVER OR REGISTRATION STAFF

Arrival Date: _____ Time: _____ Mode of Arrival:_____ Shelter Location: _____

Name: Last: _____ First: _____ MI: _____

Street Address: _____

City: _____ State: _____ Zip: _____ DOB: _____ Age: _____ Gender: _____

Phone #: (____) _____ Primary Language: _____

Residence Type: _____ Living Situation: ☐ Alone ☐ Relative ☐Other: _____

Emergency Contact Information:

Local: Name _____ Relationship: _____ Phone: _____

Non-Local: Name _____ Relationship: _____ Phone: _____

Caregiver Name: _____ Relationship: _____

Address: _____ Contact Number: _____

Do you have an animal with you? ☐ Yes ☐ No *If yes*, Does it provide a service? ☐ Yes ☐ No
If it provides a service, what types of services does it provide? _____

_____

Do you want your name included on the American Red Cross *Safe and Well List* to allow family/friends to know your well being during this event? ⊔ Yes ⊔ No

TO BE COMPLETED BY HEALTH AND MEDICAL STAFF

Medical Information:

ALLERGIES: _____

FOOD ALLERGIES/SPECIAL DIET: _____

Medical Diagnoses: _____

Primary Provider:_____ Phone: _____

Pharmacy: _____ Phone: _____

Home Health/Hospice: _____ Phone: _____

Dialysis: _____ Phone: _____

☐ Do Not Resuscitate Order (DNRO) ☐ Photo ID ☐ Person present having knowledge of resident's identity

☐ Advanced Directive Provided ☐ Client Identification Verified – ID must be on the resident at all times in shelter

Current Medications:

Medication/Strength/Frequency:

_____

_____

_____

_____

List Medical Equipment/Supplies brought to the shelter by patient _____

_____

Official Use Only

Admission Vital Signs: BP: _____/_____ Pulse: _____ Respirations: _____ Temp: _____

Objective Triage Data: _____

Medically Dependent on Electricity: ☐O2 Concentrator ☐ Feeding Pump ☐Suction ☐ Other: _____

Oxygen Dependent: ☐ 24 hour ☐ Only overnight ☐ Nebulizer ☐ CPAP
O2 type: _____ Liters flow: ___ L/min O2 company: _____ Phone: _____

☐ Assistance with medications ☐ Insulin Dependent ☐ Assistance needed with insulin

Mental Health

- Have you ever been hospitalized for psychiatric treatment? Yes / No
- Do you currently received outpatient psychiatric treatment? Yes / No
- Do you take psychiatric medication? Yes / No
- Do you use alcohol, drugs, or both? Yes / No If yes, how much?_____Last time used?_____
- Have you attempted to harm yourself? Yes / No (If yes, when & how?_____)
- Do you feel suicidal now? Yes / No Homicidal? Yes / No
- On a scale of 0-10, what level of stress are you feeling currently?

  No stress 0 1 2 3 4 5 6 7 8 9 10 Maximum Stress
- On a scale of 0-10, what level of depression are you feeling currently?

  No stress 0 1 2 3 4 5 6 7 8 9 10 Maximum Stress
- Would you like to speak with a mental health counselor? Yes / No

Is the resident?: ☐ Ambulatory ☐ Non-Ambulatory

☐Visual impairment ☐ Hearing impairment ☐ Speech impairment ☐ Cognitive impairment

☐ Mobility Impaired ☐ Walker ☐ Cane ☐ Wheelchair (Manual) ☐ Wheelchair (Powered)

☐Incontinence ☐ Dialysis Dependent ☐ Open Wounds ☐ Decubitus

DISCHARGE PLANNING

Transportation Needs: ☐ Car ☐ Bus ☐ Wheelchair Van ☐Ambulance ☐Other:_____

# of persons to transport? _____ Do you have immediate family in another shelter? ☐ Yes ☐ No

If so, w*here*? _____

☐Returning home ☐ Returning to a family member's home ☐ Other (friend, hotel, hospital, Nursing Home)

Specify discharge destination address: _____

Apartment Complex Name: _____ Apartment #: _____

- Will you be able to meet your medical needs when you return home? ☐ Yes ☐ No
- If needed, will you have a caregiver when you return home? ☐ Yes ☐ No
- What are your transportation plans to get home? _____
- Is there someone who can come get you? ☐ Yes ☐ No
  If so, who? _____ Phone: _____
- Name of Individual discharged to: _____ Phone: _____

Discharge Checklist: ☐electricity to area ☐road to home open ☐ medications loaded

☐personal effects loaded ☐ medical equipment loaded

Name of Discharge Planner: _____ Signature: _____
Discharge: Date: _____ Time: _____ Mode of D/C: _____

Comments: _____

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