

PINELLAS COUNTY EVACUATION ASSISTANCE/SPECIAL NEEDS REGISTRATION

Registration for: Special Needs Shelter Transport Assistance Both
 Once this registration form is processed, you will be contacted by your local Fire Department

LAST: _____ FIRST: _____ Male Female

STREET ADDRESS: _____ APT# _____ LOT#: _____

CITY: _____ ZIP: _____ PHONE: _____

DATE OF BIRTH: ____/____/____ EMAIL: _____ **LIVING SITUATION:** ALONE RELATIVE OTHER

SINGLE FAMILY RESIDENCE MOBILE HOME APT/CONDO COMPLEX/PARK NAME: _____

DO YOU HAVE A PET: YES NO Arrangements for pets completed. **If not**, call 727-582-2600 for assistance.

NUMBER OF DOGS _____ Approx. Weight _____ NUMBER OF CATS _____ NUMBER OF BIRDS _____ TOTAL ANIMALS _____

PRIMARY LANGUAGE SPOKEN _____

RESIDENCY: PERMANENT TEMPORARY If Temporary, START DATE _____ END DATE _____

What assistance do you require?		CHECK ALL THAT APPLY	
<input type="checkbox"/> Walking <input type="checkbox"/> Standing <input type="checkbox"/> Transferring to a Bed <input type="checkbox"/> Communicating	<input type="checkbox"/> Bathing and Showering <input type="checkbox"/> Dressing <input type="checkbox"/> Toileting <input type="checkbox"/> Feeding	<input type="checkbox"/> Wound Care <input type="checkbox"/> Ostomy <input type="checkbox"/> Catheter <input type="checkbox"/> Incontinence/Diapers	List other assistance required _____ _____
MOBILITY ASSESSMENT I am ambulatory- able to move on own? Yes <input type="checkbox"/> No <input type="checkbox"/> <input type="checkbox"/> I am bedridden <input type="checkbox"/> I use a wheelchair <input type="checkbox"/> Able to stand with assistance <input type="checkbox"/> Unable to stand with assistance I weigh over 400 Pounds <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes – approx. weight _____	ELECTRIC DEPENDENT <input type="checkbox"/> CPAP/BPAP <input type="checkbox"/> Oxygen: _____ LPM _____ No. of hours daily <input type="checkbox"/> Ventilator <input type="checkbox"/> Concentrator <input type="checkbox"/> Nebulizer <input type="checkbox"/> Feeding Pump <input type="checkbox"/> Suction Pump <input type="checkbox"/> Cardiac Monitor <input type="checkbox"/> Medicine requires refrigeration? If yes, what? _____ <input type="checkbox"/> Dialysis	COGNITIVE ASSESSMENT <input type="checkbox"/> Alzheimer's/ Dementia <input type="checkbox"/> Psychiatric Disorder <input type="checkbox"/> Obsessive Compulsive <input type="checkbox"/> Depression <input type="checkbox"/> Self-injurious or danger to others List Other Cognitive or Special Need Issues _____ _____ _____	SPECIAL CARE <input type="checkbox"/> Feeding Tube <input type="checkbox"/> Unable to swallow <input type="checkbox"/> 24 hour feedings <input type="checkbox"/> For medications only <input type="checkbox"/> Syringe feedings only <u>Client must bring all supplies needed for care to the shelter.</u> <input type="checkbox"/> Diabetes <input type="checkbox"/> Insulin Dependent <input type="checkbox"/> Oral Medication (pills) Do you have a DO NOT RESUSCITATE Order? <input type="checkbox"/> Yes (Please bring D.N.R.) <input type="checkbox"/> No Questions? Call Health Department – 727-824-6932
Have you PREARRANGED to go to a: <input type="checkbox"/> Hospital <input type="checkbox"/> Nursing Home <input type="checkbox"/> ALF <input type="checkbox"/> Other: _____			
Name of PREARRANGED facility where you will be evacuating to _____ ADDRESS _____ PHONE _____			
DOCTOR'S NAME _____		PHONE _____	
<input type="checkbox"/> Do you receive HOSPICE: NAME _____		TEAM ID _____ PHONE _____	
<input type="checkbox"/> Do you receive HOME HEALTH: NAME _____		PHONE _____	

Emergency Contact

NAME _____ RELATIONSHIP _____ PHONE _____

I certify that at least one caretaker/companion will accompany me YES HOW MANY _____

NAME _____ RELATIONSHIP _____ PHONE _____

Is caregiver registered in Special Needs database? YES NO

Form completed by (PRINT NEATLY): _____ Relationship: _____ Phone # _____	
If not completed by the applicant, do you currently possess a Power of Attorney for the individual? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Applicant Signature	
By signing this form I give my authorization for the medical information contained herein to be released to the county health department, emergency management, local fire districts and receiving facilities for the purpose of evaluating my needs and providing emergency transportation and sheltering. Records relating to registration of disabled citizens are exempt for the provisions of F.S. 119.07(1), Public Records Law. The information contained here will be kept confidential.	
_____ Signature	_____ Date