CONTACTS AND EVACUEES *PSN Applicant Name* **(from front)**:_____

_____ (____)_____ _____ (____)_____
Primary Doctor: Phone Home Health Agency Info Phone:

_____ (____)_____ _____ (____)_____
Emergency Contact Phone Caregiver Phone

___ Evacuate Spouse?
___ Evacuate Caregiver?

____Number of additional Evacuees (Excluding PSN Spouse, Caregiver)

MEDICAL INFORMATION

___Aphasia
___Arthritis
___Asthma
___Breathing Treatment
___Bronchitis
___Cancer
___Cerebral Palsy
___Comatose
___Contagious Disease – Type: _____
___Dementia ____Early ____Moderate ____Late
___Diabetes
___Dialysis: (In Home Dialysis?) ____Yes ____No
___Difficulty Speaking
___Edema
___Emphysema/COPD
___Hearing Impaired
___Heart Condition ____Stable ____Unstable
___High Blood Pressure
___Hip/Knee Replacement: When? _____
___Hospice ("end-of-life" diagnosis, not palliative care)

___Medical Equipment. Circle any that apply: (Feeding tube, Ventilator, IV, Indwelling Catheter)
___Memory Loss
___Mentally Impaired
___Multiple Sclerosis
___Muscular Dystrophy
___Nebulizer
___Open Sores
___Ostomy – Type _____
___**Oxygen** Use ____**LPM** (Number on dial)
___Parkinson's Disease: ___Early ___Mod ___Late
___Psychosis ____Controlled ____Uncontrolled
___Seizures ____Controlled ____Uncontrolled
___Sight Impaired
___Skin Disease
___Skin Infections
___Special Diet (Bring doctor-prescribed food)
___Speech Impaired
___Stroke/CVA (Limitations)

List known allergies: _____
List medication: _____
Other Comments: _____

POWER DEPENDENT

___Electric Dependent, Why? _____
___Oxygen Concentrator
___Sleep Apnea (CPAP Machine)
___Ventilator/Respirator (Machine is used to breath for you, unlike the Oxygen Concentrator and CPAP)
___Other, Please Specify: _____

MOBILITY

___I have someone assist me with all my daily activities
___I walk without help
___I use a cane
___I use a walker. Walk long distances? ___Yes ___No
___I use a wheelchair
___I am bedridden

*** CONTACT US WITH <u>CHANGES</u> TO YOUR INFORMATION, <u>NO</u> NEED TO RE-REGISTER YEARLY.**

Revised 5/26/2010