

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)

List known allergies: _____

List medication: _____

Other Comments: _____

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)

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 CHANGES TO YOUR INFORMATION, NO NEED TO RE-REGISTER YEARLY.**

Revised 5/26/2010