

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: _____ Date of Birth: ____/____/____ Male Female

STREET ADDRESS: _____ APT# _____ LOT#: _____

CITY: _____ ZIP: _____ PHONE: _____

I REQUIRE TRANSPORTATION ASSISTANCE: YES NO **LIVING SITUATION:** ALONE RELATIVE OTHER

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

CARETAKER: _____ PHONE NUMBER: _____ HOSPICE: _____, TEAM ID: _____

HOME HEALTH: _____ PHONE NUMBER: _____ HOSPICE PHONE NUMBER: _____

DO YOU HAVE A PET: YES NO Arrangements for pets completed. Call 727-582-2600 for details

SPECIAL NEED (CHECK ALL THAT APPLY) Questions? Call Health Department – 538-7277 ext. 7916

<input type="checkbox"/> Kidney Disease <input type="checkbox"/> Dialysis <input type="checkbox"/> Center: _____ <input type="checkbox"/> Days a Week: _____ <input type="checkbox"/> Diabetes <input type="checkbox"/> Insulin Dependent <input type="checkbox"/> Oral Medication (pills) <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Heart Disease <input type="checkbox"/> Stroke <input type="checkbox"/> No problems <input type="checkbox"/> Needs assistance <input type="checkbox"/> Speech Impaired <input type="checkbox"/> Cancer: <input type="checkbox"/> Year _____ <input type="checkbox"/> On Chemotherapy now <input type="checkbox"/> On Radiation now	<input type="checkbox"/> Asthma <input type="checkbox"/> Emphysema <input type="checkbox"/> COPD <input type="checkbox"/> Breathing Treatment <input type="checkbox"/> Oxygen: _____ LPM <input type="checkbox"/> Ventilator <i>Can not breathe on your own</i> <input type="checkbox"/> Mental Health Impaired <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Obsessive Compulsive <input type="checkbox"/> Violent Behavior <input type="checkbox"/> Other: _____ <input type="checkbox"/> Memory Impaired <input type="checkbox"/> Sight Impaired <input type="checkbox"/> Wears Glasses <input type="checkbox"/> Blind <input type="checkbox"/> Service Dog <input type="checkbox"/> Hearing Impaired <input type="checkbox"/> Hard of Hearing <input type="checkbox"/> Deaf	<input type="checkbox"/> Walker/Cane <input type="checkbox"/> Wheelchair user <input type="checkbox"/> Able to stand with help <input type="checkbox"/> Unable to stand <input type="checkbox"/> Bedridden only <input type="checkbox"/> Geriatric Chair <input type="checkbox"/> Incontinence <input type="checkbox"/> Occasionally <input type="checkbox"/> Wear adult diapers <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 **24 Hour Tube Feedings or unable to swallow needs to go to a hospital or nursing home	Electrical Dependent, Why? <input type="checkbox"/> CPAP/BiPAP <input type="checkbox"/> Electric Wheelchair/ Scooter <input type="checkbox"/> Nebulizer (breathing treatment) <input type="checkbox"/> Oxygen Concentrator <input type="checkbox"/> Feeding Tube <input type="checkbox"/> Other: _____ <input type="checkbox"/> Other Special Needs: _____ _____ _____ <p align="center"><u>MANDATORY SpNS</u> Dialysis, Oxygen, Breathing Treatment, Feeding Tube (syringe feedings or for medications only) Bring all supplies to SpNS</p> <input type="checkbox"/> NONE
--	---	--	---

Emergency Contacts

NAME: _____ RELATIONSHIP: _____ PHONE: _____

NAME: _____ RELATIONSHIP: _____ PHONE: _____

Prearranged: Hospital: _____ Nursing Home: _____ ALF: _____ Other: _____

NAME: _____ RELATIONSHIP: _____ PHONE: _____

Doctor's name: _____ PHONE: _____

Form completed by (PRINT NEATLY): _____ Relationship: _____ Phone # _____

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 _____

Official use only

Transport to: General Shelter Special Needs Shelter Other _____ Register for Special Needs Shelter Only

Type of Transport: Own vehicle Van/Bus Wheelchair only Ambulance

Fire Dist: _____ Grid: _____ Evac Level: _____ Shelter Name: _____

Comments: _____