2018 OKEECHOBEE COUNTY
SPECIAL NEEDS SHELTER REGISTRATION REQUEST FORM

Verification of Attendance (Y or N) _______

(No) Plan___________________________

Client has: √

Medication _______

Allergies _______

Food/Snacks _______

O2-Concentrator _______

DNRO _______

RN Reviewed (last name) _______________

Submit Forms To:

FDOH Okeechobee County,
Special Needs Shelter
1728 N.W. 9th Ave.,
Okeechobee, FL 34972-4340
Ph 863-462-5800

ALLERGIES

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____

A New Form must be submitted annually beginning March 1st

NAME: (Please Print)_______________________________Date of Birth: _______________

Street: ____City________________________

ZIP: ___________ Phone Home__________________________ Cell#):______________________

☐ Male ☐ Female Height: ___________ Weight: __________ lbs. AGE: _______

Primary Language : ☐ English ☐ Spanish ☐ Other – Specify ______________________

Home Care Information

☐ I take care of myself at home

☐ I am unable to care for myself at home

☐ I need part time nursing help at home

☐ I have full time nursing help at home

Name of caregiver who will be assisting me in the shelter:

____Relationship ________________________

Caregiver's Phone number **Home #**______________________ **Cell #**_________________________

Type of Residence: ☐ Single Family Home ☐ Manufactured Home ☐ Apartment/Condo

Complex/Park Name: __________________________________Office Phone _____________________

Physician /Provider

____ PH#_____________________________

Primary Doctor

____ PH#_____________________________

Home Health/Hospice Agency

____ PH#_____________________________

Oxygen Provider

Other Medical Support Providers

Pharmacy: ____ PH#________________________

Home Medical Equipment: ______________________________ PH#________________________

Dialysis ____ PH#________________________

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SPECIAL/MEDICAL NEEDS – Please mark all that apply

- ☐ Wound care daily or more often Type of wound: ______________________________
- ☐ Ostomy care assistance
- ☐ Catheter care assistance
- ☐ Suction equipment
- ☐ Feeding Pump
- ☐ Assistance from RN with medication or injections
- ☐ Assistance from RN with insulin and checking blood sugar
- ☐ RN to assist with IV's ***__Include copy of order from Physician__
- ☐ Ventilator dependent (stable)
- ☐ Medicines that require refrigeration
- ☐ Medical electrical equipment required to maintain health status:
  ___ CPAP/ BI-PAP ___ Nebulizer ___ Other ______________________
- ☐ Oxygen dependent: ____ 24 hr. ____ Nighttime ____ PRN Liters per minute _________

OTHER NEEDS - Please mark all that apply

Please make sure to bring these items with you and make sure that your name is on them!

- ☐ Glasses ☐ Cane ☐ Walker ☐ Wheel chair ☐ Electric wheel chair
- ☐ Hearing aide(s) ___ Right Ear ___ Left Ear ___ Both Ears
- ☐ Trained service animal Type of Animal__________________________
  What work or task has the animal been trained to perform? ____

MEDICAL AND ADDITIONAL INFORMATION – Please mark all that apply

- ☐ Seizures
- ☐ Diabetes
- ☐ Cardiac please specify: ___ Congestive Heart Failure ___ Angina ___ High Blood Pressure ___ Stroke
- ☐ Dialysis – If checked, please specify ___ Hemodialysis ___ Peritoneal
- ☐ Quadriplegic or Paraplegic – If checked, please specify:____________________________
- ☐ Mental Illness Anxiety/ Depression If checked, please specify: ______________________________________
- ☐ Alzheimer's /Dementia – If checked, please specify: **Full time caregiver must be present at all times during sheltering.**
- ☐ Immune System Problems – If checked, please specify: ____________________________
- ☐ Bed bound ☐ Unable to transfer bed to chair
- ☐ Unable to hold urine or bowel movements until bathroom is reached
- ☐ Do Not Resuscitate Order (DNRO) (**Bring original copy with you**)

TRANSPORTATION NEEDS

- ☐ I (we) have our own transportation and will drive to the shelter
- ☐ I (we) request transportation via van.
- ☐ I (we) request transportation via van/wheelchair lift
- ☐ I (we) request transportation via ambulance stretcher

If you are requesting transportation, please answer the following questions:

If using a wheelchair, can you transfer to a van seat? ☐ Yes ☐ No

If a stretcher is needed, please explain why____

List equipment that will be transported (oxygen concentrators): ____

How many people going to shelter _______ Number to be picked up______

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SIGNATURE

I grant permission to health care providers, transportation agencies, and others as necessary to provide care, and to disclose any information that is necessary to respond to my needs.
I understand that this registration is voluntary and hereby request registration in the Special Needs Shelter.

____

Signature of Registrant or Guardian **Date**

******THIS FORM MUST HAVE A SIGNATURE******

TO BE COMPLETED BY OKEECHOBEE COUNTY HEALTH DEPARTMENT STAFF

- ☐ **Meets criteria for Special Needs Shelter**
- ☐ **Nursing Home/Assisted Living Facility**
- ☐ **Hospital**
- ☐ **General Shelter**

Signature: ______________ **Date:**________

** To be completed by Discharge Planner **

Discharge Planning: Plans If Client Cannot Return Home

Should your home sustain damage and you are not able to immediately return home, please list what your plans are and who can be contacted that you can stay with. Please list their names and phone numbers (including cell numbers).

☐ Returning Home ☐ Returning to Another Family Member's Home ☐ Other (Friend, Hotel, Hospital, Nursing Home)

Discharge Address____

Name of individual discharge to__________________________________ Phone Number(s): __________________

Contact Person: __________________________________ Phone Number(s): _________________

Contact Person (Non-Local): _________________________ Phone Number(s): _________________

Discharge checklist: ☐ Electricity to area ☐ Road to Home Open ☐ Equipment and Personal Belongings Loaded

Name of Discharge Planner________________________________Signature___________________________________

Dischage Date_____________________ Time________________Mode of Discharge__________________________

Comments____

____

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MEDICATIONS
Please list your medications, your dosage, full name of the doctor who prescribed the medication and the doctor's phone number. **Attach additional paper if necessary.**

Please list medication or provide a printed list with request form.

NAME OF MEDICATION	DOSAGE	FULL NAME OF PRESCRIBING PHYSICIAN	PHYSICIAN'S PHONE NUMBER (include area code)

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