ORANGE COUNTY HEALTH SERVICES DEPARTMENT
PEOPLE WITH SPECIAL NEEDS QUESTIONNAIRE

PLEASE PRINT

○ New ○ Update

Registrant's General Information

First Name ______________________ Middle Name ______________ Last Name ______________

Date of Birth ______________ Gender ○ Male ○ Female

Race ______________ Is English Spoken? ○ Yes ○ No If no, what is language? ______________

Registrant's Residential Address Information

Home Address ______________________________ Apt/Lot No. ______________

City ______________ Zip +4 ______________ Mobile Home Park/Apartment Complex Name ______________

Registrant's Mailing Address ○ Same as Residential Address Information

Mailing Address ______________________ City ______________________ Zip Code +4 ______________

Registrant's Phone Information

Home Phone ( ) ______________ Work Phone ( ) ______________ Cell Phone ( ) ______________ Other ( ) ______________

Agency / Registrant's Caregiver / Registrant's Emergency Contact Information

What is the name of your Home Health Care Agency? ______________________ Agency Phone Number ______________

What is the name of your Medical Equipment Supplier? ______________________ Supplier Phone Number ______________

Name of Caregiver who will accompany you to shelter? ______________________ Caregiver Phone ______________

Emergency Contact Name ______________________ Contact Phone ______________

Transportation

Will you need transportation assistance in an emergency? ○ Yes ○ No

If yes, please check ONE of the following:

○ I can sit in a regular car seat. ○ I must stay in a wheelchair.

○ I can walk but can't climb stairs. ○ I am confined to a bed.

Select All That Apply

○ Guide Dog/Service Animal ○ Walker

○ Use TDD/TTY ○ Own Pet

○ Motorized Scooter/Wheelchair Type of Pet ______________

○ White Cane

Registrant's Medical Information **Select the most appropriate CATEGORY (A, B, C). Then mark ALL conditons that apply to you.**

Height ________ Weight ________

⬭ CATEGORY A

Anyone who can walk without assistance and needs no outside professional assistance performing the activities of daily living. Anyone who can provide their own medical care and does not have any life threatening problems. Please mark all that apply.

- ⬭ Asthma
- ⬭ Arthritis
- ⬭ Legally Blind
- ⬭ Pacemaker
- ⬭ Non-Insulin Dependent Diabetes
- ⬭ Insulin Dependent Diabetes
- ⬭ Hypertension
- ⬭ High Blood Pressure
- ⬭ Other Condition (Specify)

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⬭ CATEGORY B

Anyone requiring minor medical assistance to perform their activities of daily living, who is acompanied by a caregiver. Please mark all that apply.

- ⬭ Alzheimers (Early Stages)
- ⬭ Aphasia
- ⬭ CAPD-Dialysis
- ⬭ Catheter
- ⬭ Cerebral Palsy
- ⬭ COPD
- ⬭ Cancer
- ⬭ Congestive Heart Failure (CHF)
- ⬭ Cerebrovascular Accident (CVA)
- ⬭ Emphysema
- ⬭ G-Tube
- ⬭ Hemodialysis
- ⬭ Hip Replaced
- ⬭ IV
- ⬭ Knee Replaced
- ⬭ Muscular Dystrophy-Severe (MD)
- ⬭ Multiple Sclerosis (MS)
- ⬭ Osteoarthritis
- ⬭ Osteoporosis
- ⬭ Oxygen Dependent
- ⬭ Parkinson's
- ⬭ Rashes Fluid
- ⬭ Senile Dementia
- ⬭ Sores Fluid
- ⬭ Terminal
- ⬭ Wheelchair Permanenent
- ⬭ Other Conditiion (Specify)

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⬭ CATEGORY C

Anyone who is permanently restricted to bed with a stable medical condition and requiring ongoing medical supervision. Those people who cannot perform the activities of daily living on their own, nor have a caregiver. Anyone with an unstable medical condition and/or requiring constant medical attention. Anyone on a life support system. Please mark all that apply.

- ⬭ Alzheimers (Advanced)
- ⬭ Bed (Permanent)
- ⬭ Cardiac (Unstable)
- ⬭ Contagious (Severe)
- ⬭ Comatose
- ⬭ Cystic Fibrosis
- ⬭ Psychosis
- ⬭ Respirator
- ⬭ Seizure
- ⬭ Terminal (Endstage)
- ⬭ Ventilator
- ⬭ Other Condition (Specify)

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Registrant's Signature

I certify this information is correct. I understand I am responsible for all expenses associated with transportation and admittance to the hospital. I hereby grant permission to Orange County for the release of this information to emergency response agencies. I understand by signing this form, I grant emergency responders permission to enter my home and provide for my needs in an emergency.

________________________ ____________

Registrant's Signature Date

________________________ ____________

Case Manager Signature if completing with Client Date

Please send completed forms to:
Orange Co. People with Special Needs Program
2002-A E. Michigan Street
Orlando, FL 32806
Phone: 407-836-9319 Fax: 407-836-7625