SPECIAL NEEDS SHELTER REGISTRATION REQUEST FORM

Submit Forms To: Okeechobee County Health Department, Special Needs Shelter, PO Box 1879, Okeechobee, FL 34973

FORMS NEED TO BE COMPLETED ANNUALLY BEGINNING MARCH 1ST

The Special Needs Shelter is intended for patients who can be accommodated on a simple cot (approximately 10 inches off the floor) and can ambulate to bathrooms. Patients in wheelchairs must be able to assist with transfer to use bathroom facilities. Patients must bring medications, all medical supplies and equipment, bedding, and special dietary needs with them to the shelter. One person should accompany the patient as a caregiver. Patients with living wills must bring a copy.

NAME: (Please Print)____ Date Of Birth: ________________

STREET: ____

MAILING ADDRESS IF DIFFERENT: ____

CITY: ____________________________ ZIP: ___________ PHONE: _______________________________

MALE ☐ FEMALE ☐ **PRIMARY LANGUAGE**: ☐ English ☐ Spanish ☐ Other – Specify _____________

CONTACT PERSON: ___________________ RELATIONSHIP: _____________PHONE: _____________

CARE GIVER: _____________________________RELATIONSHIP: _______________ PHONE: _________

DIRECTIONS TO HOME: ____

____

ATTENDING PHYSICIAN: __________________________________ PHONE: __________________________

HEALTH CARE AGENCY (Full Name/No Abbreviations) PHONE NUMBER

____ ______________________________

SPECIAL NEEDS

- ☐ Wound care daily or more often
- ☐ Ostomy care assistance
- ☐ Catheter care assistance
- ☐ RN to administer daily injections, or I.V.'s
- ☐ Ventilator dependent
- ☐ Professional assistance with pain medication
- ☐ Medical electrical equipment required to maintain health status:
  ___ CPAP BI-PAP ___ Nebulizer ___ Other _________
- ☐ Requires assistance with insulin and checking blood sugar
- ☐ Oxygen dependent: ____ 24 hr. ___ PRN ___ Nighttime

OTHER NEEDS

- ☐ Bed Bound
- ☐ Unable to transfer bed to chair
- ☐ Confused - disoriented
- ☐ Uncontrolled incontinence
- ☐ Visual, hearing or speech impairment
- ☐ Other: _______________________
  ____

TRANSPORTATION REQUIREMENTS

- ☐ Request transportation via ambulance stretcher
- ☐ Request transportation via wheelchair/van/bus
- ☐ Has own transportation

TO BE COMPLETED BY OKEECHOBEE COUNTY HEALTH DEPARTMENT STAFF

- ☐ Meets criteria for Special Needs Shelter
- ☐ Requires other than Special Needs Shelter
  - ☐ Nursing Home
- ☐ No Special Needs

Signature: ______________ Date:________

POST SHELTER PLANS

The shelter may be open up to 72 hours after an event. If you are unable to return to your home at that time due to power outage or structural damage, what plans do you have? ___________________________________

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