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: _____ Gender ☐Male ☐Female

STREET ADDRESS:_____ APT#_____ LOT#:_____

CITY:_____ ZIP:_____ PHONE:_____

DATE OF BIRTH: _____/_____/_____ EMAIL: _____ **LIVING SITUATION**: ☐ALONE ☐RELATIVE ☐OTHER

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

DO YOU HAVE A PET: ☐YES ☐NO ☐Arrangements for pets completed**. If not**, call 727-582-2600 for assistance.

NUMBER OF DOGS _____ Approx. Weight_____ NUMBER OF CATS_____ NUMBER OF BIRDS_____ TOTAL ANIMALS_____

PRIMARY LANGUAGE SPOKEN _____

RESIDENCY: ☐PERMANENT ☐TEMPORARY If Temporary, START DATE_____ END DATE_____

What assistance do you require? CHECK ALL THAT APPLY

☐ Walking ☐ Standing ☐ Transferring to a Bed ☐ Communicating	☐ Bathing and Showering ☐ Dressing ☐ Toileting ☐ Feeding	☐ Wound Care ☐ Ostomy ☐ Catheter ☐ Incontinence/Diapers	*List other assistance required* _____ _____ _____

MOBILITY ASSESSMENT

I am ambulatory- able to move on own? Yes ☐ No ☐

☐ I am bedridden
☐ I use a wheelchair
☐ Able to stand with assistance
☐ Unable to stand with assistance

I weigh over 400 Pounds
☐ Yes ☐ No
If Yes – approx. weight ____

ELECTRIC DEPENDENT

☐ CPAP/BPAP
☐ Oxygen: _____LPM
____ No. of hours daily

☐ Ventilator
☐ Concentrator
☐ Nebulizer
☐ Feeding Pump
☐ Suction Pump
☐ Cardiac Monitor
☐ Medicine requires refrigeration? If yes, what?
_____
☐ Dialysis

COGNITIVE ASSESSMENT

☐ Alzheimer's/ Dementia
☐ Psychiatric Disorder
☐ Obsessive Compulsive
☐ Depression
☐ Self-injurious or danger to others

List Other Cognitive or Special Need Issues
_____
_____
_____
_____

SPECIAL CARE

☐ **Feeding Tube**
☐ *Unable to swallow*
☐ *24 hour feedings*
☐ *For medications only*
☐ *Syringe feedings only*

Client must bring all supplies needed for care to the shelter.

☐ Diabetes
☐ Insulin Dependent
☐ Oral Medication (pills)

Do you have a **DO NOT RESUSCITATE** Order**?**
☐ Yes **(*Please bring D.N.R.)***
☐ No

Questions? Call Health Department – 727-824-6932

Have you PREARRANGED to go to a:
☐Hospital ☐Nursing Home ☐ALF ☐ Other: _____

Name of PREARRANGED facility where you will be evacuating to _____

ADDRESS _____ PHONE_____

DOCTOR'S NAME _____ PHONE_____

☐Do you receive HOSPICE: NAME_____ TEAM ID_____PHONE _____

☐ Do you receive HOME HEALTH: NAME _____PHONE _____

Emergency Contact

NAME _____RELATIONSHIP_____ PHONE_____

I certify that at least one caretaker/companion will accompany me ☐YES HOW MANY _____

NAME_____RELATIONSHIP_____PHONE_____

Is caregiver registered in Special Needs database? ☐YES ☐NO

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

If not completed by the applicant, do you currently possess a Power of Attorney for the individual? ☐YES ☐NO

Applicant Signature

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

Mail completed form to: Pinellas County Emergency Management, 10750 Ulmerton Rd. Building 1, Suite 267, Largo, FL 33778 or fax to 727-464-4024. For more information, please call 727-464-3800. Rev. 2017

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