INSTRUCTIONS FOR COMPLETING THIS FORM

PURPOSE:

Emergency preparedness, response, and recovery begin at the individual level. The best way to prevent injury and loss of life during an emergency evacuation is advance planning that prepares the individual for such an event. Experience shows that without proper planning and community preparedness, disasters become even more chaotic and unnecessary loss of life and injuries result. In short, individuals may face increased risk, higher death rates, and difficulty in evacuating without prior planning at both the household and agency levels.

Prior to, during, or after a disaster, there is often a need to establish areas of safe refuge or shelters to temporarily house those who are displaced as a result of a disaster. It is essential to be prepared to shelter or provide safe refuge during an emergency or disaster to all individuals within a community who do not have an alternative such as friends and family. The management of nursing, convalescent, retirement and other group facilities are responsible for the evacuation and sheltering of their own residents. Note: Medical Needs Shelters do not provide actual medical care, but do traditionally provide amenities such as back-up power for those who are dependent on medical devices.

INSTRUCTIONS:

This is a tool to help home health, hospice and other agencies assist their patients/clients in developing an appropriate emergency evacuation plan. This document, if it's an electronic PDF, can be filled out on your computer.

This form should be completed by the patient/client, their responsible party (local family member, friend, legally authorized individual, etc.), or the current healthcare provider, and reviewed annually and updated at the time of an impending natural disaster.

Complete all sections of the evacuation information form. Be sure to indicate all "yes or no" choice questions. If more than one person in your household needs assistance during evacuations, each one must complete a separate form. The patient or their responsible party must sign the evacuation information form.

Section A. Please complete the requested Patient/Client information.

Section B. Please complete the requested Emergency Contacts for the Patient/Client.

Section C. Please show where a Patient/Client is planning to stay during a disaster or emergency event.

Section D. Any anticipated assistance that the Patient/Client requires for emergency planning should be indicated here.

Section E. Please enter specific medical care information about the Patient/Client; be as detailed as necessary.

Freudenthal HOME HEALTH

PATIENT/CLIENT EVACUATION PLANNING: A Tool for Emergency Preparedness

This is a tool to help home health, hospice and other agencies assist their patients/clients in developing an appropriate emergency evacuation plan. Pursuant to HIPAA statutes, some information in this document may be confidential and handled as HIPAA and other privacy law require. Medical Needs Shelters do NOT provide medical care so this will not be a good option for sheltering someone receiving home care. This document is strictly designed to help caseworkers and healthcare providers develop evacuation and sheltering plans for patients.

A. PATIENT INFORMATION:

TODAYS DATE:

Last Name: _____ First Name: _____ MI: _____ Sex: ❑ Male ❑ Female

Address: _____ City: _____ State:____ Zip:_____

Mailing Address (If different from above) : _____

Date of Birth:_____ Age: _____ Telephone: _____ Cell: _____

Work Phone: _____ Other Phone: _____

Is English Your Preferred Language? ❑ Yes ❑ No **IF NO**, Your preferred language is: _____

Living Situation: ❑ Living Alone ❑ With Spouse ❑ With Spouse & Children ❑ With Parents ❑ With Other Relative
❑ With Non-Relative ❑ With Child(ren) ❑ Service Animal ❑ Pets

B. EMERGENCY CONTACTS:

Contact: _____ Relationship: _____ Telephone:_____

Agency Caseworker (Primary) : _____ (Other) : _____

Telephone:_____ Cell: _____ Work: _____

Person Completing This Form (if different from above) : _____

Address/Company : _____

C. DURING A DISASTER I PLAN TO :

❑ Stay with a Relative/Friend in the Area
❑ Stay in Residence
❑ Stay with a Relative/Friend Outside the Area
❑ Other Plans (describe):_____
❑ **As a Last Resort:** Go to a Shelter (*Caseworker can help determine other shelter needs*)

D. ASSISTANCE REQUIRED:

Do you anticipate needing the assistance of another person? _____ ❑ Yes ❑ No
If so, do you have a caregiver that could go with you? _____ ❑ Yes ❑ No

If yes, Name: _____ Relationship: _____

Telephone: _____ Cell:_____ Work: _____

Transportation Plan: ❑ Car ❑ Taxi ❑ Bus ❑ Van ❑ Ambulance

Name of Transportation Company or Family Member and Telephone Number: _____

NOTE: *Inability to ride in a car, taxi, bus, or van requires transportation by ambulance. If you require special/ambulance transportation and/or a hospital, you must make those arrangements yourself.*

Freudenthal HOME HEALTH

PATIENT/CLIENT EVACUATION PLANNING: A Tool for Emergency Preparedness

Patient Name: _____

E. MEDICAL CARE INFORMATION: (Check all that apply.)

- ❑ Memory Impaired
- ❑ Speech Impaired
- ❑ Sight Impaired
- ❑ Hearing Impaired
- ❑ Mobility Impaired
  - ❑ Walker/Cane
  - ❑ Wheelchair, Manual
  - ❑ Wheelchair/Scooter, Powered
  - ❑ Other: _____
- ❑ Mental Health Impaired
  - › Describe: _____
- ❑ Alcohol/Substance/Tobacco Use or Dependence
- ❑ Insulin Dependent

  Is Insulin Self-Administered? ❑ Yes ❑ No
- ❑ Open Wounds
- ❑ Incontinence
- ❑ Obesity – Weight
- ❑ Service Animal:
- ❑ Bedridden

  If so, height & weight: _____
- ❑ Oxygen Dependent, Portable
- ❑ Oxygen Supplier and Phone Number: _____
- ❑ Dependent Upon Electrically Energized Equipment
  - › Electrical Equipment Required:
    - ❑ Nebulizer
    - ❑ Respirator Dependent
      - › Details: _____
    - ❑ Oxygen Concentrator
    - ❑ Dialysis Dependent
      - ❑ Hemodialysis
      - ❑ Peritoneal Dialysis
      - ❑ Dialysis, Portable
- ❑ Other Electrical Equipment Required: _____

  _____

  _____
- ❑ Other (any information that is critical to the overall care of the patient/client): _____

  _____

  _____

Allergies and/or Special Diet: _____

Medications/Dosages: _____

_____

_____

Primary Physician Name: _____ Telephone: _____

Pharmacy Name: _____ Telephone: _____

Health Insurance Company Name: _____ Telephone: _____