Florida Department of Health - Hillsborough Shelter Evaluation Form

(PLEASE PRINT)

Failure to complete the entire form WILL delay your evaluation!

Last Name:	First Name:	Middle Initial:	Last 4 digit of SS: XXX-XX-

Sex: ☐Male ☐Female	Height:	Weight:	Date of Birth:	Telephone:	Primary Language:

Street Address:	Lot/Apt #	City:	Zip Code:

Living Arrangements: ☐Alone ☐With Relative ☐Other:

Mailing Address (if different):	City:	Zip Code:	Mobile Home?: ☐Yes ☐No Mobile Home Park Name:

Primary Emergency Contact Name:	Relationship:	Telephone:
Secondary Emergency Contact Name:	Relationship:	Telephone:
Caregiver Name:	Relationship:	Telephone:

Only immediate family living in household can accompany you to the shelter.

Primary Doctor's Name: Telephone:	Home Health Agency: Telephone:

Name Your Medical Problems: (Bring List of Medications with you to the Shelter)

Are you under the care of HOSPICE? ☐Yes ☐No *If YES, who is your Hospice provider?*

TRANSPORTATION: Do you need a ride to the Shelter? ☐Yes ☐No

Mobility Assessment: (Check all that apply)

- ☐ I can walk
- ☐ Wheelchair/scooter
- ☐ Walker
- ☐ Cane
- ☐ Bedridden
- ☐ Uses lift to get out of bed
- ☐ Hearing Impaired
- ☐ Deaf
- ☐ Blind
- ☐ Partially Blind

Cognitive Assessment: (Check all that apply)

- ☐ Mental Health Problems
- ☐ Psychiatric
- ☐ Alzheimer's
- ☐ Autism
- ☐ Conduct Disorder
- ☐ Obsessive Compulsive
- ☐ Anxiety
- ☐ Depression
- ☐ Dementia

Electric Dependent: (Check all that apply)

- ☐ Feeding Pump
- ☐ Suction Pump
- ☐ Nebulizer
- ☐ Cardiac Monitor
- ☐ Apnea Monitor
- ☐ CPAP/BPAP
- ☐ Ventilator
- ☐ Concentrator
- ☐ Oxygen _____ No. of hrs. daily
  _____ Liter Flow _____ Portable Tank
- ☐ Dialysis
- ☐ Other _____

Special Care: (Check all that apply)

- ☐ Open Wound
- ☐ Ostomy
- ☐ Catheter
- ☐ Incontinence/Adult Diapers

Assistance required with medication?

- ☐ I need a nurse or caregiver to administer medication

I have Trained Service Animal: What kind? _____	What arrangements have you made for your pets? _____

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 of Patient / Guardian **Date Signed**

Return form to: Florida Department of Health – Hillsborough PHP PO Box 5135 Tampa, Fl 33675-5135
Or FAX to (813) 276-8689. For more information call (813) 307-8063