

**OKALOOSA COUNTY  
SPECIAL NEEDS PATIENT REGISTRATION FORM**

**Return completed form to: Okaloosa County Emergency Management, 90 College Boulevard East, Niceville, FL 32578  
FAX: (850) 651-7170 / Phone: (850) 651-7150**

**To be completed by agency:**  
 Initial  Change

**To be completed by Okaloosa County Health Department:**  
Special Needs Shelter Eligible:  Yes  No

**PLEASE PRINT**

Last Name:		First Name:	Middle Initial:
Phone Number:		Date of Birth (mm/dd/yyyy): / /	Gender: <input type="checkbox"/> M <input type="checkbox"/> F
Street Address:		City:	Zip Code:
Caregiver:			Pets: <input type="checkbox"/> Dog <input type="checkbox"/> Cat <input type="checkbox"/> Other _____
Emergency Contact Name:			Phone Number:

**Medical Information**

 **MAIN ILLNESS (DO NOT LEAVE BLANK):**

(Check All That Apply)

- |  |  |   |   |
|--|--|---|---|
| <input type="checkbox"/> Medical Dependence on Electricity     | <input type="checkbox"/> Diabetic – Insulin            | <input type="checkbox"/> Home IV Therapy                      | <input type="checkbox"/> G or NG Feeding Tube |
| <input type="checkbox"/> Life Sustaining Medications           | <input type="checkbox"/> Diabetic – Non-insulin        | <input type="checkbox"/> Wound Care                           | <input type="checkbox"/> Vision Impaired      |
| <input type="checkbox"/> Requires Assistance with Daily Living | <input type="checkbox"/> Epilepsy-Uncontrolled         | <input type="checkbox"/> Anxiety/Depression                   | <input type="checkbox"/> Hearing Impaired     |
| <input type="checkbox"/> Requires Monitoring of Vital Signs    | <input type="checkbox"/> Epilepsy-Controlled with Meds | <input type="checkbox"/> Dialysis Dependent                   | <input type="checkbox"/> Speech Impaired      |
| <input type="checkbox"/> Requires Assistance with Medications  | <input type="checkbox"/> Incontinent Bowel/Bladder     | <input type="checkbox"/> Cardiac History                      | <input type="checkbox"/> Heart Disease        |
| <input type="checkbox"/> Requires Routine Nursing              | <input type="checkbox"/> Memory Impaired               | <input type="checkbox"/> Cardiac History-Controlled with Meds |   |
| <input type="checkbox"/> Allergies _____                       | <input type="checkbox"/> Mental-Totally Dependent      | <input type="checkbox"/> Mental-Mild Confusion                |   |

Home Health Agency:	Phone Number:
Physician:	Phone Number:

**Oxygen Dependent**

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> Oxygen Dependent<br>Hours Per Day _____ | <input type="checkbox"/> Nebulizer<br>Liter Flow _____ | <input type="checkbox"/> Concentrator<br>Oxygen Supplier _____ | <input type="checkbox"/> Portable Tank |
|--|--|--|--|

**Special Circumstances**

- |   |                                       |                                     |  |
|---|---------------------------------------|-------------------------------------|--|
| <input type="checkbox"/> Continuous Equipment | <input type="checkbox"/> Over 300 Lbs | <input type="checkbox"/> Ventilator | <input type="checkbox"/> Combative/Violent                           |
| <input type="checkbox"/> Bedridden            | <input type="checkbox"/> Wheelchair   | <input type="checkbox"/> Walker     | <input type="checkbox"/> Service Animal _____<br><small>type</small> |

**Disaster Plan**

- |  |   |   |                                      |
|--|---|---|--------------------------------------|
| <input type="checkbox"/> Staying at Home | <input type="checkbox"/> To Special Needs Shelter | <input type="checkbox"/> To Any Shelter | <input type="checkbox"/> Other _____ |
|--|---|---|--------------------------------------|

**Transportation**

- |   |  |                                      |
|---|--|--------------------------------------|
| <input type="checkbox"/> No Transportation Required | <input type="checkbox"/> Transportation Only | <input type="checkbox"/> Car/Van/Bus |
| <input type="checkbox"/> Ambulance                  | <input type="checkbox"/> Wheelchair Lift     |                                      |

I, the undersigned, give permission to release the information above to the Emergency Management Office for assistance with evacuation in the event of a natural disaster/emergency. I also give emergency service providers, whether paid or volunteer, permission to enter my home in case of a declared emergency.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Person Completing Form: \_\_\_\_\_ Agency Name: \_\_\_\_\_

**FOR USE BY SUBMITTING AGENCY ONLY: DELETION CODES (PLEASE CHECK ONE TO REMOVE FROM REGISTRATION)**

- |                                       |  |  |  |
|---------------------------------------|--|--|--|
| <input type="checkbox"/> <b>MOVED</b> | <input type="checkbox"/> <b>DISCHARGED</b> | <input type="checkbox"/> <b>DECEASED</b> | <input type="checkbox"/> <b>NO LONGER NEEDS ASSISTANCE</b> |
|---------------------------------------|--|--|--|

**EMERGENCY MANAGEMENT USE ONLY**

- |   |   |
|---|---|
| <input type="checkbox"/> Special Needs Shelter – Transportation Required    | <input type="checkbox"/> Special Needs Shelter – Electricity – Transportation Required    |
| <input type="checkbox"/> Special Needs Shelter – No Transportation Required | <input type="checkbox"/> Special Needs Shelter – Electricity – No Transportation Required |
| <input type="checkbox"/> General Shelter – Transportation Required          |   |