

SPECIAL NEEDS SURVEY

DATE: _____

LAST NAME: _____ **FIRST NAME:** _____

SSN: _____ **DOB:** _____ **SEX:** Male [] Female []

Address: _____

Apt./ Lot No.: _____ **City:** _____ **State:** _____ **Zip:** _____

Cross Street(s): _____

Apartment or Complex Name: _____

CHECK ONE: Home: [] Apartment: [] Mobile Home: [] Other: []

TELEPHONE NO.: Home: _____ Other: _____

LANGUAGE: English: _____ Spanish: _____ Other: _____

NEXT OF KIN: _____	CAN YOU CARE FOR YOURSELF? Yes/No []
Relationship: _____	If not who does? _____
Address: _____	Relationship: _____
Home Phone: _____	Address: _____
Work Phone: _____	Home Phone: _____
Other: _____	Work Phone: _____

Physician: _____

Phone: _____

Hospital: _____

HOME HEALTH: Yes/No []	HOME HEALTH CENTER NAME: _____			
DAILY CARE REQUIREMENTS: (Check requirements that apply)				
Oxygen []	Dialysis []	Dressings []	Airway Suction []	Catheters []
Special Feeding Equipment []	Electrical Support Equipment []	IV []		
Other: _____				
MOBILITY: Walks []		Walks with Assistance []		Wheelchair []
If bedridden, can be moved in wheelchair: Yes /No []		Own Wheelchair Yes /No []		Bedridden []
OTHER DISABILITIES: Deep Wounds []		Contagious Disease []		Chronic Infections []
Other: _____				
SPECIAL REQUIREMENTS NOT LISTED ABOVE: _____				

Transportation needed to evacuate: Ambulance [] Medical Van [] Car []

Patient will need electrical power assistance for medical equipment: Yes /No []

How many persons will need evacuation with patient: _____

Evacuation Destination: _____

Alternate Evacuation Destination: _____