SPECIAL MEDICAL NEEDS PROGRAM
LEE COUNTY EMERGENCY MANAGEMENT

PO BOX 398, FORT MYERS, FL 33902-0398
FOR INFORMATION CALL 239-533-0640 / FAX# 239-477-3636

Applications will NOT be processed when Lee County is in the 5-day hurricane forecast cone.

PERSONAL INFORMATION

Last Name | Suffix | First Name | M.I.

ID | Date of Birth | Primary language spoken

Gender | Weight | Height – feet | inches

PHYSICAL ADDRESS

Address | Street | Unit#

City | State | Zip Code

Subdivision/Community | Gate Code

Residence type (single detached home, duplex, Apt/Condo, boat, mobile/manuf home) | Living Situation (Live alone, Live with Relative, Live with Caregiver, Other

Stairs? Number of Flights | Utility Company (FPL, LCEC, Other)

Primary Phone | Secondary Phone | 7-1-1 Relay/TTY

Email address

MAILING ADDRESS

☐ Same as above

Mailing Address | Unit# | PO Box

City | State | Zip Code

CAREGIVER INFORMATION

Caregiver Last Name | Caregiver First Name

Caregiver Primary Phone | Caregiver Secondary Phone

Caregiver email

Do you require a 24 hr caregiver? | Will caregiver stay with you at the shelter?

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EMERGENCY CONTACT - LOCAL

Emergency Last Name		Emergency First Name	
Emergency Primary Phone		Emergency Secondary Phone	
Address		Street	Unit#
City	State	Zip Code	Relationship
Local Emergency Email			

EMERGENCY CONTACT – OUT OF AREA

Emergency2 Last Name		Emergency2 First Name	
Emergency2 Primary Phone		Emergency2 Secondary Phone	
Address		Street	Unit#
City	State	Zip Code	Relationship
Emergency2 Email			

HEALTH MEDICAL ASSESSMENT Doctor Information

Doctor's Name _____ Doctor's Phone Number _____

☐ I have a Do Not Resuscitate (DNR). Your original document, signed by your doctor, MUST be with you at the shelter.

SPECIAL CARE ASSESSMENT

☐ Blind/Low Vision
☐ Deaf/Hard of Hearing
☐ Frail / Elderly
☐ Need Asst with Medications
☐ Hemodialysis – at home
☐ Hemodialysis – at facility
☐ Chronic Wounds
☐ Decubitus Ulcers
☐ IM or IV Injections
☐ Feeding Tube
☐ Insulin Dependent
Hemodialysis frequency _____
☐ Recent Hospital Discharge
☐ C-Diff
☐ MRSA
☐ Terminally Ill – Hospice
☐ Seizures

Dialysis/Home Health Center _____ Phone _____

Other _____

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COGNITIVE ASSESSMENT

- ☐ Dementia
- ☐ Alzheimer's Disease
- ☐ Developmental Impairment
- ☐ Autism Spectrum
- ☐ Conduct Disorder
- ☐ Psychiatric Disorder
- ☐ Bipolar Disorder
- ☐ Parkinson's
- ☐ Anxiety
- ☐ Depression
- ☐ Causes harm to self/others
- ☐ Obsessive-Compulsive Disorder

Autism Level (Asperger's-high functioning, Moderate, Low functioning, Non-verbal) _____

Other _____

MOBILITY ASSESSMENT

- ☐ I can walk on my own
- ☐ I use a standard wheelchair
- ☐ I have a Service Animal
- ☐ Amputee
- ☐ Paraplegic
- ☐ Quadriplegic
- ☐ Multiple Sclerosis (MS)
- ☐ Muscular Dystrophy (MD)
- ☐ I need a Hoyer Lift
- ☐ I need an attendant to help with walking
- ☐ I can stand and walk cane
- ☐ I use a motorized wheelchair/scooter
- ☐ I use a walker/wheeled seat walker
- ☐ White Cane
- ☐ I weigh over 300 pounds
- ☐ I am bed-bound
- ☐ I require stretcher transport
- ☐ ALS (Lou Gehrig's Disease)

Other _____

WHAT HELP DO YOU REQUIRE?

- ☐ Walking
- ☐ Standing
- ☐ Getting in/out of bed
- ☐ Dressing
- ☐ Toileting
- ☐ Feeding
- ☐ Wound Care
- ☐ External / Self Catheter
- ☐ Communicating
- ☐ Ostomy
- ☐ Bowel/Bladder Incontinence
- ☐ Bathing/Showering
- ☐ Asst with Medications

Other _____

ELECTRICITY ASSESSMENT

- ☐ CPAP / BiPAP
- ☐ Nebulizer
- ☐ Feeding pump
- ☐ Ventilator
- ☐ Refrigerated Meds
- ☐ Apnea Monitor
- ☐ Cardiac Monitor

☐ I require Oxygen Liters per minute I require _____

Oxygen usage (24 hrs/day, nights only, as needed, with CPAP/BiPAP)

Oxygen Provider

Phone Number

ADDITIONAL MEDICAL INFORMATION

☐ I have allergies

TRANSPORTATION NEEDS

☐ I will provide my own transportation

☐ I need a ride – Paratransit bus

☐ I am bed-bound and require stretcher transport

PET SHELTERING NEEDS

Name	Type	Breed	Weight	☐ Carrier/Crate ☐ Leash/Collar

Pet notes

Records relating to the registration of special needs citizens are exempt from the provisions of S.119.07(1), Florida Statutes.

I understand this registration is voluntary and do hereby request to be registered in the Lee County Special Medical Needs Program. The information contained herein is true and correct to the best of my knowledge. I understand there are limitations to the services and levels of care that are available.

I hereby grant permission to medical providers, transportation agencies, and others, to provide care and respond to my needs, and for the disclosure of any information necessary to do so. I also grant permission to emergency response agencies to enter my resident for the purpose of emergency search and rescue, and authorize the release of information necessary for these agencies to perform these services.

In an effort to ensure the safety of all shelter residents, a background screen will be run on all people evacuating to the Special Medical Needs Shelter, including the caregiver.