

# SPECIAL NEEDS REGISTRATION FORM

LAST NAME \_\_\_\_\_ FIRST \_\_\_\_\_ MIDDLE \_\_\_\_\_

SSN \_\_\_\_\_ (optional) SEX \_\_\_\_\_ LANGUAGE \_\_\_\_\_ RACE \_\_\_\_\_

DATE OF BIRTH \_\_\_\_ / \_\_\_\_ / \_\_\_\_ AGE \_\_\_\_ PHONE (\_\_\_\_) \_\_\_\_\_ TDD? Yes No

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_ TODAY'S DATE \_\_\_\_\_

## EMERGENCY CONTACT DATA:

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_

Work Phone \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

## OVER ALL FUNCTIONAL AND MEDICAL STATUS

- |                     |                          |                              |                          |                               |                          |
|---------------------|--------------------------|------------------------------|--------------------------|-------------------------------|--------------------------|
| ADL Impairments     | <input type="checkbox"/> | Functional Status _____      | Oxygen                   | <input type="checkbox"/>      |                          |
| Bedridden           | <input type="checkbox"/> | Hearing Impaired             | <input type="checkbox"/> | Requires 24 Hr. Care          | <input type="checkbox"/> |
| Blind               | <input type="checkbox"/> | Hypertension/Stroke          | <input type="checkbox"/> | Respirator                    | <input type="checkbox"/> |
| Cane                | <input type="checkbox"/> | IADL Impairments             | <input type="checkbox"/> | Self-Declared Disability      | <input type="checkbox"/> |
| Client HDM          | <input type="checkbox"/> | Insulin Dependent            | <input type="checkbox"/> | Service Animal                | <input type="checkbox"/> |
| Client is Caregiver | <input type="checkbox"/> | Limited Vision               | <input type="checkbox"/> | Service Relieves a Care Giver | <input type="checkbox"/> |
| Client is Oriented  | <input type="checkbox"/> | Lives Alone                  | <input type="checkbox"/> | Sight Impaired                | <input type="checkbox"/> |
| Deaf                | <input type="checkbox"/> | Medical Electricity Required | <input type="checkbox"/> | Special Eligibility           | <input type="checkbox"/> |
| Diabetes            | <input type="checkbox"/> | Mobile Home                  | <input type="checkbox"/> | Special Needs Client          | <input type="checkbox"/> |
| Dialysis            | <input type="checkbox"/> | Mobility Impaired            | <input type="checkbox"/> | Speech Impaired               | <input type="checkbox"/> |
| Economically Needy  | <input type="checkbox"/> | Monitor                      | <input type="checkbox"/> | Walker                        | <input type="checkbox"/> |
| Enhanced Care       | <input type="checkbox"/> | Nutritional Scale            | <input type="checkbox"/> | Wheel Chair                   | <input type="checkbox"/> |
| Ensure              | <input type="checkbox"/> | Other Electricity Required   | <input type="checkbox"/> | Willing to be Transported     | <input type="checkbox"/> |

MEDICATIONS: \_\_\_\_\_

MEDICAL CONDITIONS: \_\_\_\_\_

PHYSICAL CONDITIONS: \_\_\_\_\_

ALLERGIES: \_\_\_\_\_

DEPENDENCIES (medical equipment): \_\_\_\_\_

OXYGEN PROVIDER: \_\_\_\_\_ PHONE: \_\_\_\_\_

HOME HEALTH AGENCY: \_\_\_\_\_ PHONE: \_\_\_\_\_

**SPECIAL NEEDS REGISTRATION FORM**

**Primary Physician:** \_\_\_\_\_  
First Name Last Name Phone

**Pharmacy:** \_\_\_\_\_  
Name Phone

**In the event of an emergency, I prefer to: (Check)**

Stay at home.  
Do you have all necessary medications and equipment?  Yes  No

Go to a shelter.  
Who will be your caretaker?  
Do you have a service animal?  Yes  No

When bringing a service animal to a shelter, please have identification indicating your need for the animal.

Stay with family/friends.

Address and Phone:

Other \_\_\_\_\_

Will you need transportation?  Yes  No

**Information Release**

I certify that the above information is correct. I hereby grant permission to New Hanover County Department of Emergency Management and the Department of Aging Retired & Senior Volunteer Program and volunteers working under the direction of these agencies to use this information for the following purposes ONLY: (1) to include my name/information in the County Special Needs Registry; and/or (2) to give to emergency response agencies for assistance with evacuation or aid in the event of a disaster or emergency. This information is confidential.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

GUARDIAN: \_\_\_\_\_

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**Report prepared by:**

Agency/Organization: \_\_\_\_\_ Phone: \_\_\_\_\_

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**Please mail form to:**

New Hanover County  
Special Needs Registry  
2222 S. College Road  
Wilmington, NC 28403  
Questions/Comments: (910) 798-6416

For Office Use Only:  
RSVP File # \_\_\_\_\_  
Date of Registration \_\_\_\_\_