DILLSBURG EMERGENCY MANAGEMENT AGENCY
SPECIAL NEEDS INFORMATION FORM

Name of Resident: _____

Resident's Address: _____

Telephone No.: _____ Cellular No.: _____

Date of Birth: _____ SSN #: _____

Insurance Company: _____

Identification No.: _____

Doctor's Name: _____

Doctor's Telephone #: _____

Current Medications: _____

Dosage Schedule: _____

Pharmacy Name/Address: _____

Pharmacy Phone No.: _____

Your Medical Profile (Current Health Conditions): _____

MEDICAL DEVICES SURVEY

Do you use/have any of the following Medical Devices? (Please circle all that applies)

Crutches Walker Wheelchair Bedroom Toilet Motorized Scooter Nebulizer Unit

Home Oxygen Respiratory Monitor IV Home Unit Heart Monitor Glucose Monitor

Are you any of the following? (Please circle all that applies)

Bedridden Blind Deaf Diabetic Pacemaker Patient Stoma Patient Feeding Tube Patient

Insulin Use? Y N Insulin Type: _____ Type of use: Pump Syringes Pills

Other: _____
(please specify)

Is anyone Non-English speaking? Y N

What language is spoken? _____

Does anyone require 24-hour nursing care in home? Y N

What Nursing Home Care is used? _____