



Cecil County Department of Emergency Services Needs Assessment Registry Form



Last Name:		First Name:		M.I.
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female		Date of Birth:		Telephone:
Address:		Apt:	City:	Zip Code:
Type of Dwelling: <input type="checkbox"/> Single Family <input type="checkbox"/> Mobile <input type="checkbox"/> Apartment/Condo: <input type="checkbox"/> Ground Floor <input type="checkbox"/> 2 + Floor				
Living Situation: <input type="checkbox"/> Alone <input type="checkbox"/> With Spouse <input type="checkbox"/> With Relatives <input type="checkbox"/> In an assisted care home				
Emergency Contact:		Relationship:		Telephone:
Caregiver Name :		Relationship:		Telephone:
Mobility Assessment (check all that apply)		Electrical Dependency (check all that apply)		
<input type="checkbox"/> I can walk	<input type="checkbox"/> Wheelchair/scooter	<input type="checkbox"/> Feeding Pump	<input type="checkbox"/> Suction Pump	
<input type="checkbox"/> Walker	<input type="checkbox"/> Cane	<input type="checkbox"/> Nebulizer	<input type="checkbox"/> Cardiac Monitor	
<input type="checkbox"/> Bedridden	<input type="checkbox"/> Uses lift to get out of bed	<input type="checkbox"/> Apnea Monitor	<input type="checkbox"/> CPAP/BiPAP	
<input type="checkbox"/> Hearing Impaired	<input type="checkbox"/> Partially Blind	<input type="checkbox"/> Ventilator	<input type="checkbox"/> Concentrator	
<input type="checkbox"/> Deaf	<input type="checkbox"/> Blind	<input type="checkbox"/> Oxygen: Liter Flow ____ Portable Tank Yes or No		<input type="checkbox"/> Other _____
<input type="checkbox"/> Bariatric				
Cognitive Assessment (Check all that apply)		Special Care (check all that apply)		
<input type="checkbox"/> Alzheimer's	<input type="checkbox"/> Dementia	<input type="checkbox"/> I need a nurse to administer my medication		
<input type="checkbox"/> Autism	<input type="checkbox"/> Depression	<input type="checkbox"/> I have a valid Maryland DNR/MOLST form		
<input type="checkbox"/> Anxiety	Other _____	Other _____		
I require Dialysis: <input type="checkbox"/> Yes <input type="checkbox"/> No How many times per week? _____				
If I must leave my home in an emergency situation I would most likely.....				
<input type="checkbox"/> Transport myself or be transported to a family or friends house				
<input type="checkbox"/> Already have a written family emergency/disaster plan; <input type="checkbox"/> I have attached a copy				
<input type="checkbox"/> I will need to go to a 24/hr care center because I require 24 hour monitoring				
<input type="checkbox"/> I will seek refuge in a public shelter <input type="checkbox"/> Other: _____				
I will need public Transportation Assistance				
<input type="checkbox"/> Yes		<input type="checkbox"/> No		
NOTE: The type of public transportation assistance you will receive (i.e. ambulance, wheelchair van, bus) will be determined by Emergency Response Professionals based on the information provided in this assessment and availability of resources.				
I have a Trained Service Animal		Definition: A Trained Service Animal is any dog that is individually trained to do work or perform tasks to a person with a disability including physical, sensory, psychiatric, intellectual, or other mental disability.		
<input type="checkbox"/> Yes <input type="checkbox"/> No				
Type _____	Breed _____			
I have a Companion Animal		<input type="checkbox"/> Yes <input type="checkbox"/> No	Number _____	
Type _____	Breed _____			

I certify that the above information is correct to the best of my knowledge. By signing this form I give my authorization for the medical information contained herein to be released to the Cecil County, MD Department of Emergency Services (CCDES) under the terms of For Official Use Only. I understand that this information will be utilized by CCDES and other public safety organizations to provide assistance to me in emergency situations. I understand that this will not be forwarded to commercial or private organizations for any reason. I provide and release this information voluntarily.

Form Completed By: (Print) _____ Signature (If Caregiver) _____

Patient Signature _____ Date: _____

-----**(Fold Here)**-----**(Fold Here)**-----

Return Address:



Cecil County Department of Emergency Services

107 Chesapeake Blvd., Suite 108

Elkton, MD 21921