ALERT: POSSIBLE COVID-19 CASE

Important Information about ME

Emergency Contacts, Abridged Medical History, Medication Regimen, Allergy Information, Assistance Needs

I have an intellectual and/or developmental disability. My parent/guardian or support professional believes I am showing signs of COVID-19 infection. If they cannot come with me into the hospital, please refer to the information provided here and call my guardian, and service provider for any clarifications.

MY PERSONAL INFORMATION			
First Name:	**Middle Initial:**	**Last Name:**	**DOB:**
Address:		**City, State, ZIP:**	
Name of Parent/Guardian:		**Parent/Guardian Phone/Email:**	
Name of Provider Agency QP:		**Provider Agency QP Phone/Email:**	
PCP Contact Name:		**PCP Phone/Email:**	

MY CURRENT SYMPTOMS/RISK FACTORS		
Current COVID-19 Symptoms:	**When Did it Start?**	**COVID-19 Severity Risk Factors (check all that apply):**
Temp. Over 100°F		☐ Age 60 or Older ☐ Bowel Disease (Chron's, Colitis, or Similar) ☐ Cancer (Current or Previous) ☐ Cerebral Palsy ☐ Chemotherapy ☐ Chronic Heart Disease ☐ Chronic Lung Disease (Asthma or Similar) ☐ Diabetes ☐ Medication Induced Immunosuppressive Risk ☐ On Prednisone, Dexamethasone, or any medication ending in the letters "-ab"
Dry Cough		
Malaise/Fatigue		
Shortness of Breath		
Bloodshot Eyes		
Diarrhea		
Loss of Smell/Taste		
Other(s), please specify:		☐ Down's Syndrome ☐ Hypertension ☐ New Chest Pain ☐ Paralysis (Due to Any Cause) ☐ Recurrent Pneumonia ☐ Severe Scoliosis Other: Other:

MEDICATIONS				
Medication:	**New Medication:** (added within the last 2 weeks)	**Dosage/Frequency:**	**Preferred Form:** (liquid, pill, etc.)	**Special Medication Instructions:**

Do any of the above medications cause immunosuppression as a secondary effect? If yes, please list medication names here:

MY MEDICAL HISTORY		
Health Issue/Diagnosis:	**When Did it Start?**	**Notes:**

MY ALLERGIES	SEVERITY

ADDITIONAL NOTES:

MY ACTIVITIES OF DAILY LIVING			
Bathing/Grooming	Independent	Needs Assistance Physical and/or Verbal	Needs Total Assistance Physical and/or Verbal
Dressing/Undressing	Independent	Needs Assistance Physical and/or Verbal	Needs Total Assistance Physical and/or Verbal
Eating	Independent	Needs Assistance Physical and/or Verbal	Needs Total Assistance Physical and/or Verbal
Restroom Use/Incontinence	Independent	Needs Assistance Physical and/or Verbal	Needs Total Assistance Physical and/or Verbal
Ambulation	Independent	Needs Assistance	Needs Total Assistance
Communication	Talkative	Needs Assistance Physical and/or Verbal	Non-Verbal/Uses Device
Social Preferences	Social	Not Social	Varies
Sleep Schedule	Typical	Inverted	Intermittent/Variable

MY LIKES AND DISLIKES	
I express myself by:	
I calm myself by:	
When I am happy, I:	
When I am sad, I:	
When I am scared, I:	
When I am angry, I:	
My likes:	
My dislikes:	

I have a DNR Order:

YES NO UNSURE

If yes, list location if known:

I have a Living Will:

YES NO UNSURE

If yes, list location if known:

I have brought the following equipment supports with me:

- Communication Device
- G-Tube Feeding/Supplies
- Cough Assistance Machine
- Catheterization Supplies
- Other:

This is how I use my equipment supports:

These are the behavioral supports I need: