Print Form

Hillsborough County Health Department Shelter Evaluation Form

(PLEASE PRINT)

Failure to complete the entire form WILL delay your evaluation!

Last Name:	First Name:	Middle Initial:	Last 4 digit of SS: XXX-XX-

Sex: ◯Male ◯Female	Height:	Weight:	Date of Birth:	Telephone:	Primary Language:

Street Address:	Lot/Apt #	City:	Zip Code:

Living Arrangements: ◯ Alone ◯ With Relative ◯ Other:

Mailing Address(if different):	City:	Zip Code:	Mobile Home?: ◯Yes ◯ No Mobile Home Park Name:

Local Emergency Contact Name:	Relationship:	Telephone:
Out of Town Emergency Contact Name	Relationship:	Telephone:
Caregiver Name:	Relationship:	Telephone:

Only immediate family living in household can accompany you to the shelter.

Primary Doctor's Name: Telephone	Home Health Agency: Telephone

Name Your Medical Problems: (Bring List of Medications with you to the Shelter)

Are you under the care of HOSPICE? ◯ Yes ◯ No *(HOSPICE patients do NOT need to complete this form. They should contact their HOSPICE caregiver to arrange for special needs shelter and/or transportation.)*

TRANSPORTATION: Do you need a ride to the Shelter? ◯ Yes ◯ No

Mobility Assessment: (Check all that apply)

- ☐ I can walk
- ☐ Walker
- ☐ Bedridden
- ☐ Hearing Impaired
- ☐ Blind
- ☐ Wheelchair/scooter
- ☐ Cane
- ☐ Uses lift to get out of bed
- ☐ Deaf
- ☐ Partially Blind

Cognitive Assessment: (Check all that apply)

- ☐ Mental Health Problems
- ☐ Psychiatric
- ☐ Alzheimer's
- ☐ Autism
- ☐ Conduct Disorder
- ☐ Obsessive Compulsive
- ☐ Anxiety
- ☐ Depression
- ☐ Dementia

Electric Dependent (Check all that apply)

- ☐ Feeding Pump
- ☐ Suction Pump
- ☐ Nebulizer
- ☐ Cardiac Monitor
- ☐ Apnea Monitor
- ☐ CPAP/BPAP
- ☐ Ventilator
- ☐ Concentrator
- ☐ Oxygen _____ No. of hrs. daily _____ Liter Flow _____ Portable Tank
- ☐ Dialysis
- ☐ Other _____

Special Care: (Check all that apply)

- ☐ Open Wound
- ☐ Ostomy
- ☐ Catheter
- ☐ Incontinence/Adult Diapers

Assistance required with medication?

- ☐ I need a nurse or caregiver to administer medication

I have Trained Service Animal: What kind? _____	What arrangements have you made for your pets? _____

By signing this form I give my authorization for the medical information contained herein to be released to the county health department, emergency management, local fire districts, and receiving facilities for the purpose of evaluating my needs and providing emergency transportation and sheltering. Records relating to registration of disabled citizens are exempt for the provisions of F.S. 119.07(1), Public Records Law. The information contained here will be kept confidential.

_____ **Signature of Patient / Guardian**

_____ **Date Signed**

Return form to: Hillsborough County Health Department PO Box 5135 Tampa, Fl 33675-5135
Or FAX to (813) 276-8689. For more information call (813) 307-8063

For Office Use Only (Check all that apply):

Special Needs Shelter: _____ Red Cross Shelter: _____ Hospital: _____ Shriners: _____ Dialysis: _____ FAHA_____ Aging Services_____

T