



PATIENT/CLIENT EVACUATION PLANNING: A TOOL FOR EMERGENCY PREPAREDNESS

Agency Name: _____

This is a tool to help home health, hospice and other agencies assist their patients/clients in developing an appropriate emergency evacuation plan. Pursuant to HIPAA statutes, some information requested in this evacuation information form may be confidential and will only be made available to other emergency response agencies.

A. PATIENT/CLIENT INFORMATION:

Today's Date: _____

Name: _____
Last First MI

Sex: Male Female

Street Address: _____
Street City State Zip

Mailing Address (if different from above) _____

Date of Birth: _____ Age _____ Telephone: _____ Cell Phone: _____

Work Phone: _____ Other Phone: _____

Is English Your Preferred Language Yes No If No, Your Preferred Language: _____

Living Situation: Living Alone With Spouse With Spouse & Child(ren)
 With Parents With Other Relative With Non-Relative With Child(ren)
 Service Animal Pets

B. EMERGENCY CONTACTS:

Contact: _____ Relationship: _____ Telephone: _____

Agency Caseworker (Primary): _____ (Other): _____

Telephone: _____ Cell phone: _____ Work phone: _____

Person Completing This Form (if different from above) _____

Address/Company _____

C. DURING A DISASTER I PLAN TO:

- Stay With a Relative/Friend in the Area Stay With a Relative/Friend Outside the Area
- Stay in Residence
- Other Plans (describe): _____
- As a Last Resort:** Go to a Shelter (Caseworker can help determine other shelter needs)

D. ASSISTANCE REQUIRED:

Do You Anticipate Needing the Assistance of Another Person? Yes No

If So, Do You Have a Caregiver That Could Go With You? Yes No

If Yes, Name: _____ Relationship: _____

Telephone: _____ Cell Phone: _____ Work Phone: _____

Transportation Plan: Car Taxi Bus Van Ambulance

Name of Transportation Company or Family Member: _____

Transportation Company Telephone Number: _____

Note: Inability to ride in a car, taxi, bus, or van requires transportation by ambulance. If you require special/ambulance transportation and/or a hospital, you must make those arrangements yourself.

PATIENT/CLIENT EVACUATION PLANNING: A TOOL FOR EMERGENCY PREPAREDNESS

Patient/Client Name: _____

Page 2

E. MEDICAL CARE INFORMATION: (Check those that apply)

- | | |
|---|---|
| <ul style="list-style-type: none"> <input type="checkbox"/> Memory Impaired <input type="checkbox"/> Speech Impaired <input type="checkbox"/> Sight Impaired <input type="checkbox"/> Hearing Impaired <input type="checkbox"/> Mobility Impaired <ul style="list-style-type: none"> <input type="checkbox"/> Walker/Cane <input type="checkbox"/> Wheelchair, Manual <input type="checkbox"/> Wheelchair/Scooter, Powered <input type="checkbox"/> Other: _____ <input type="checkbox"/> Mental Health Impaired <ul style="list-style-type: none"> <input type="checkbox"/> Describe: _____ <input type="checkbox"/> Alcohol/Substance/Tobacco Use or Dependence <input type="checkbox"/> Insulin Dependent <ul style="list-style-type: none"> Insulin Self-Administered <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Open Wounds <input type="checkbox"/> Incontinence <input type="checkbox"/> Obesity – Weight <input type="checkbox"/> Service Animal: _____ <input type="checkbox"/> Bedridden <ul style="list-style-type: none"> <input type="checkbox"/> If so, height & weight: _____ | <ul style="list-style-type: none"> <input type="checkbox"/> Oxygen Dependent, Portable <ul style="list-style-type: none"> <input type="checkbox"/> Oxygen Supplier and Phone Number: _____ <input type="checkbox"/> Dependent Upon Electrically Energized Equipment <ul style="list-style-type: none"> Electrical Equipment Required: <ul style="list-style-type: none"> <input type="checkbox"/> Nebulizer <input type="checkbox"/> Respirator Dependent <ul style="list-style-type: none"> <input type="checkbox"/> Details: _____ <input type="checkbox"/> Oxygen Concentrator <input type="checkbox"/> Dialysis Dependent <ul style="list-style-type: none"> <input type="checkbox"/> Hemodialysis <input type="checkbox"/> Peritoneal Dialysis <input type="checkbox"/> Dialysis, Portable <input type="checkbox"/> Other Electrical Equipment Required: _____ <input type="checkbox"/> Other (any information that is critical to the overall care of the patient/client): _____ |
|---|---|

Allergies and/or Special Diet: _____

Medications/Dosages: _____

Primary Physician Name: _____ Telephone: _____

Pharmacy Name: _____ Telephone: _____

Health Insurance Company Name: _____ Telephone: _____

Note to Caseworker: DHEC has a Special Medical Needs Shelter Brochure that can be downloaded at this internet address: <http://www.scdhec.gov/administration/library/ML-025390.pdf>



Instructions for Completing DHEC Form 0548

PATIENT/CLIENT EVACUATION PLANNING: A TOOL FOR EMERGENCY PREPAREDNESS

PURPOSE:

Emergency preparedness, response, and recovery begin at the individual level. The best way to prevent injury and loss of life during an emergency evacuation is advance planning that prepares the individual for such an event. Experience shows that without proper planning and community preparedness, disasters become even more chaotic and unnecessary loss of life and injuries result. In short, individuals may face increased risk, higher death rates, and difficulty in evacuating without prior planning at both the household and agency levels.

Prior to, during, or after a disaster, there is often a need to establish areas of safe refuge or shelters to temporarily house those who are displaced as a result of a disaster. It is essential to be prepared to shelter or provide safe refuge during an emergency or disaster to all individuals within a community who do not have an alternative such as friends and family. The management of nursing, convalescent, retirement and other group facilities are responsible for the evacuation and sheltering of their own residents.

INSTRUCTIONS:

This is a tool to help home health, hospice and other agencies assist their patients/clients in developing an appropriate emergency evacuation plan. This document, if it's an electronic PDF, can be filled out on your computer.

This form should be completed by the patient/client, their responsible party (local family member, friend, legally authorized individual, etc.), or an Agency Caseworker, and reviewed annually and updated at the time of an impending hurricane.

Complete all sections of the evacuation information form. Be sure to indicate all "yes or no" choice questions. If more than one person in your household needs assistance during evacuations, each one must complete a separate form. The patient or their responsible party must sign the evacuation information form.

Section A. Please complete the requested Patient/Client information.

Section B. Please complete the requested Emergency Contacts for the Patient/Client.

Section C. Please show where a Patient/Client is planning to stay during a disaster or emergency event.

Section D. Any anticipated assistance that the Patient/Client requires for emergency planning should be indicated here.

Section E. Please enter specific medical care information about the Patient/Client; be as detailed as necessary.

OFFICE MECHANICS AND FILING:

Copies of this form used by the Department of Health and Environmental Control (DHEC) shall be filed and maintained there in accordance with the most restrictive retention schedule assigned to this document or other documents contained in the file.