

## 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: <input type="checkbox"/> Male <input type="checkbox"/> Female	Height:	Weight:	Date of Birth:	Telephone:	Primary Language:
Street Address:		Lot/Apt #	City:		Zip Code:
Living Arrangements: <input type="checkbox"/> Alone <input type="checkbox"/> With Relative <input type="checkbox"/> Other:					
Mailing Address(if different):		City:	Zip Code:	Mobile Home?: <input type="checkbox"/> Yes <input type="checkbox"/> No Mobile Home Park Name:	
<u>Local</u> Emergency Contact Name:		Relationship:		Telephone:	
<u>Out of Town</u> Emergency Contact Name		Relationship:		Telephone:	
Caregiver Name:		Relationship:		Telephone:	
<b>Only immediate family living in household can accompany you to the shelter.</b>					
Primary Doctor's Name: Telephone			Home Health Agency: Telephone		
Name Your Medical Problems: (Bring List of Medications with you to the Shelter)					
<b>Are you under the care of HOSPICE? <input type="checkbox"/> Yes <input type="checkbox"/> 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.)</b>					
<b>TRANSPORTATION: Do you need a ride to the Shelter? <input type="checkbox"/> Yes <input type="checkbox"/> No</b>					
Mobility Assessment: (Check all that apply)			Electric Dependent (Check all that apply)		
<input type="checkbox"/> I can walk <input type="checkbox"/> Walker <input type="checkbox"/> Bedridden <input type="checkbox"/> Hearing Impaired <input type="checkbox"/> Blind			<input type="checkbox"/> Wheelchair/scooter <input type="checkbox"/> Cane <input type="checkbox"/> Uses lift to get out of bed <input type="checkbox"/> Deaf <input type="checkbox"/> Partially Blind		
Cognitive Assessment: (Check all that apply)			<input type="checkbox"/> Feeding Pump <input type="checkbox"/> Nebulizer <input type="checkbox"/> Apnea Monitor <input type="checkbox"/> Ventilator <input type="checkbox"/> Oxygen _____ No. of hrs. daily _____ Liter Flow _____ Portable Tank <input type="checkbox"/> Dialysis <input type="checkbox"/> Other _____		
<input type="checkbox"/> Mental Health Problems <input type="checkbox"/> Alzheimer's <input type="checkbox"/> Autism <input type="checkbox"/> Conduct Disorder <input type="checkbox"/> Obsessive Compulsive <input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Dementia			<input type="checkbox"/> Wheelchair/scooter <input type="checkbox"/> Cane <input type="checkbox"/> Uses lift to get out of bed <input type="checkbox"/> Deaf <input type="checkbox"/> Partially Blind		
<input type="checkbox"/> Psychiatric <input type="checkbox"/> Suction Pump <input type="checkbox"/> Cardiac Monitor <input type="checkbox"/> CPAP/BPAP <input type="checkbox"/> Concentrator			<input type="checkbox"/> Open Wound <input type="checkbox"/> Ostomy <input type="checkbox"/> Catheter <input type="checkbox"/> Incontinence/Adult Diapers Assistance required with medication? <input type="checkbox"/> 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.					
_____ <b>Signature of Patient / Guardian</b>			_____ <b>Date Signed</b>		
<b>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</b>					
For Office Use Only (Check all that apply):					
Special Needs Shelter: _____ Red Cross Shelter: _____ Hospital: _____ Shriners: _____ Dialysis: _____ FAHA: _____ Aging Services: _____					

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