

CAUTION: POSSIBLE COVID-19 CASE

Patient Summary for Person with Developmental Disability

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

I have a 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, service provider, and the county board of DD for any clarifications.

PERSONAL INFORMATION			
First Name:	Middle Initial:	Last Name:	DOB or Age:
Address:		City, State, ZIP:	
Name of Parent/Guardian:		Parent/Guardian Phone/Email:	
Name of Direct Support Professional (DSP):		DSP Phone/Email:	
County Board of DD Contact:		County Board Contact Phone/Email:	

CURRENT SYMPTOMS / RISK FACTORS		
Current COVID-19 Symptoms:	When Did it Start?	Patient's COVID-19 Severity Risk Factors (check all that apply):
<input type="checkbox"/> Temp. Over 100°F <input type="checkbox"/> Dry Cough <input type="checkbox"/> Malaise/Fatigue <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Bloodshot Eyes <input type="checkbox"/> Diarrhea <input type="checkbox"/> Loss of Smell/Taste <input type="checkbox"/> Other (please specify) <input type="checkbox"/> Other (please specify)		<div style="display: flex; flex-wrap: wrap;"> <div style="width: 50%;"> <input type="checkbox"/> Age 60 or Older <input type="checkbox"/> Bowel Disease <small>(Chron's, Colitis, or Similar)</small> <input type="checkbox"/> Cancer <small>(Current or Previous)</small> <input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> Chemotherapy <input type="checkbox"/> Chronic Heart Disease <input type="checkbox"/> Chronic Lung Disease <small>(Asthma or Similar)</small> <input type="checkbox"/> Diabetes <input type="checkbox"/> On Prednisone, Dexamethasone, or any medication ending in the letters "-ab" </div> <div style="width: 50%;"> <input type="checkbox"/> Down syndrome <input type="checkbox"/> Hypertension <input type="checkbox"/> New Chest Pain <input type="checkbox"/> Paralysis <small>(Due to Any Cause)</small> <input type="checkbox"/> Recurrent Pneumonia <input type="checkbox"/> Severe Scoliosis <input type="checkbox"/> Other: <input type="checkbox"/> Other: </div> </div>

MEDICATIONS			
Medication:	New Medication: <small>(added within the last 2 weeks)</small>	Dosage/Frequency:	Preferred Form: <small>(liquid, pill, etc.)</small>
	<input type="checkbox"/>		
	<input type="checkbox"/>		
	<input type="checkbox"/>		
	<input type="checkbox"/>		
	<input type="checkbox"/>		
	<input type="checkbox"/>		

(MORE INFORMATION ON REVERSE)

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

PATIENT ALLERGIES	SEVERITY

PATIENT HAS DNR ORDER:
 YES NO UNSURE
 If yes, list order's location if known:

PATIENT HAS LIVING WILL:
 YES NO UNSURE
 If yes, list will's location if known:

PERSONAL ASSISTANCE NEEDS			
Bathroom Use:	<input type="checkbox"/> Independent	<input type="checkbox"/> Needs Assistance	<input type="checkbox"/> Needs Total Assistance
Eating:	<input type="checkbox"/> Independent	<input type="checkbox"/> Needs Assistance	<input type="checkbox"/> Needs Total Assistance
Mobility:	<input type="checkbox"/> Independent	<input type="checkbox"/> Needs Assistance	<input type="checkbox"/> Uses Assistive Device
Communication:	<input type="checkbox"/> Talkative	<input type="checkbox"/> Limited Speech	<input type="checkbox"/> Non-Verbal/Uses Device
Social Preference:	<input type="checkbox"/> Social	<input type="checkbox"/> Not Social	<input type="checkbox"/> Varies
Sleep Schedule:	<input type="checkbox"/> Typical	<input type="checkbox"/> Inverted	<input type="checkbox"/> Intermittent/Variable

ADDITIONAL NOTES:

PATIENT'S SELF EXPRESSION, LIKES, AND DISLIKES:	
I express myself by:	
I calm myself by:	
When I'm happy, I:	
When I'm sad, I:	
When I'm scared, I:	
When I'm angry, I:	
My likes:	
My dislikes:	

PATIENT HAS MASK/FACE SENSITIVITY (IF YES, SPECIFY IN NOTES ABOVE):
 YES
 NO

PATIENT HAS GENERAL TOUCH SENSITIVITY (IF YES, SPECIFY IN NOTES ABOVE):
 YES
 NO

To download this form, visit www.oacbdd.org/covidform

This form has been created and distributed by the Ohio Association of County Boards of DD with substantial input and guidance from Dr. Susan Abend of the Right Care Now Project.

