COVID-19 DISABILITY FORM

Please answer the questions on this form to help physicians provide you with proper medical treatment in case you need to go to the hospital for COVID-19 related symptoms. Complete as many of the questions as possible.

Personal Information

Name		
Address		
City	State	Zip
Phone	Email	
Date of Birth	Age	Gender
Marital Status	SS#	
Blood Type		

I live *(check one box):*

❑ By myself ❑ With my family ❑ With roommates ❑ In a group home

❑ Supported living ❑ Nursing home ❑ Other *(please describe)*

Physician and Emergency Contact

Primary Care Physician (PCP)	
PCP Phone	Fax
Emergency Contact or Advocate 1	
Name	Relationship
Phone	
Emergency Contact or Advocate 2	
Name	Relationship
Phone	

Who do you trust to make medical decisions if you aren’t able to?

Name ____

Phone number ____

Communication

How do you communicate best? *(check all that apply)* ❑ Talking ❑ Writing or typing things down ❑ Pictures ❑ Using sign language ❑ Pointing to words ❑ Using a voice app ❑ Assistive Devices ❑ I cannot communicate in a way you will understand, please ask family, staff or guardian ____
Do you have any triggers *(e.g., being touched, trauma, doctors of a particular gender, noises, lighting, smells, textures):* **What is your response to triggers?** **How can you best be helped when triggered?**

Medical Information

Allergies *(include reactions to allergies)*
Medications and doses

Supplements and doses
Medical Devices in Your Body
Surgeries and Dates
Do you use tobacco *(e.g., cigarettes, cigars, or chewing tobacco)?* ❑ no ❑ yes, please list ___________________________ how often____________ **Do you use any other drugs** *(e.g., marijuana, cocaine, or opiates)?* ❑ no ❑ yes, please list ___________________________ how often____________ **Do you use alcohol?** ❑ no ❑ yes, please list ___________________________ how often____________

Disability Related Information

Disability / Injury / Diagnosis *(include Date of Injury / Diagnosis)*
Sensation and function levels

Non-Ambulating / Ambulating *(include devices you use such as wheelchairs, braces and crutches)*
Best way to move and lift you
Bladder Care and routine
Bowel program information
Skin Care *(example: feet should be covered with loose-fitting socks; roll every couple hours)*
Circulation Care *(example: elevated legs while in bed and/or type of bed needed to prevent pressure)*
Other relevant information *(muscle spasms, nerve pain, autonomic dysreflexia, seizures, etc.)*

For patients who are their own guardian/have capacity:

Do you have *(circle all)*

1) an advance directive   2) a health care agent   3) a living will   4) a MOLST form?

If so please bring a copy of each document to the hospital

If while you are in the hospital you can't breathe on your own, do you want a machine to help breathe for you? *(Mechanical ventilation)*

- ❑ I do not want it at all?
- ❑ I want a trial to see if it is helping?
- ❑ I want it for as long as it is needed?

If while you are in the hospital your heart stops, do you want your doctor to try to restart it with pushing on your chest, medications, and electric shocks? *(Resuscitation)* ❑ yes ❑ no

If you can't eat or drink like you normally do, do you want liquid food and water to be given to you through a tube to your stomach or in a vein? *(Artificial nutrition/hydration)* ❑ yes ❑ no