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?**	**Possible COVID-19 Severity Risk Factors (check all that apply):**	
Blood O_2 Saturation < 92%		Age 60 or Older	HIV/AIDS
Chills		Cancer (Current or Previous)	Hypertension
Diarrhea		Cerebral Palsy	Liver Disease
Dry Cough		Chemotherapy (Current)	Lung Disease (Asthma or Similar)
Headache		Chest Pain	Paralysis (Due to Any Cause)
Loss of Smell/Taste		Diabetes	Recurrent Pneumonia
Malaise/Fatigue		On Dialysis	Severe Obesity
Muscle Pain		Down Syndrome	Severe Scoliosis
Shaking		Heart Disease	Transplant:
Shortness of Breath		Other:	
Temp. Over 100°F		On Prednisone or any medication ending in the letters “-sone” or “-ab”	

MEDICATIONS			
Medication:	**New Medication:** (added within the last 2 weeks)	**Dosage/Frequency:**	**Preferred Form:** (liquid, pill, etc.)

(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:	Independent	Needs Assistance	Needs Total Assistance
Eating:	Independent	Needs Assistance	Needs Total Assistance
Mobility:	Independent	Needs Assistance	Uses Assistive Device
Communication:	Talkative	Limited Speech	Non-Verbal/Uses Device
Social Preference:	Social	Not Social	Varies
Sleep Schedule:	Typical	Inverted	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

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.