Cecil County Department of Emergency Services
Needs Assessment Registry Form

Last Name:	**First Name:**		**M.I.**
Sex: ☐ Male ☐ Female	**Date of Birth:**		**Telephone:**
Address:	**Apt:**	**City:**	**Zip Code:**
Type of Dwelling: ☐ Single Family ☐ Mobile ☐ Apartment/Condo: ☐Ground Floor ☐2 + Floor			
Living Situation: ☐ Alone ☐ With Spouse ☐ With Relatives ☐ In an assisted care home			
Emergency Contact:	**Relationship:**		**Telephone:**
Caregiver Name :	**Relationship:**		**Telephone:**

Mobility Assessment (check all that apply)		**Electrical Dependency (**check all that apply)	
☐I can walk	☐Wheelchair/scooter	☐Feeding Pump	☐Suction Pump
☐Walker	☐Cane	☐Nebulizer	☐Cardiac Monitor
☐Bedridden	☐Uses lift to get out of bed	☐Apnea Monitor	☐CPAP/BiPAP
☐Hearing Impaired		☐Ventilator	☐Concentrator
☐Deaf	☐ Partially Blind	☐Oxygen: Liter Flow ____ Portable Tank Yes or No	
☐Bariatric	☐ Blind		☐Other _____
Cognitive Assessment (Check all that apply)		**Special Care** (check all that apply)	
☐Alzheimer's	☐Dementia	☐I need a nurse to administer my medication	
☐Autism	☐Depression	☐I have a valid Maryland DNR/MOLST form	
☐Anxiety	Other_____	Other_____	

I require Dialysis: ☐ Yes ☐ No **How many times per week?** _____

If I must leave my home in an emergency situation I would most likely……

☐Transport myself or be transported to a family or friends house
☐Already have a written family emergency/disaster plan; ☐I have attached a copy
☐I will need to go to a 24/hr care center because I require 24 hour monitoring
☐I will seek refuge in a public shelter ☐ Other: _____

I will need public Transportation Assistance

☐Yes ☐No

NOTE: The type of public transportation assistance you will receive (i.e. ambulance, wheelchair van, bus) will be determined by Emergency Response Professionals based on the information provided in this assessment and availability of resources.

I have a Trained Service Animal	**Definition:** A Trained Service Animal is any **dog** that is individually trained to do work or perform tasks to a person with a disability including physical, sensory, psychiatric, intellectual, or other mental disability.
☐Yes ☐No	
Type _____ Breed _____	

I have a Companion Animal ☐Yes ☐No Number _____

Type _____ Breed _____

I certify that the above information is correct to the best of my knowledge. By signing this form I give my authorization for the medical information contained herein to be released to the Cecil County, MD Department of Emergency Services (CCDES) under the terms of For Official Use Only. I understand that this information will be utilized by CCDES and other public safety organizations to provide assistance to me in emergency situations. I understand that this will not be forwarded to commercial or private organizations for any reason. I provide and release this information voluntarily.

Form Completed By: (Print) _____ Signature (If Caregiver) _____

Patient Signature_____ Date: _____

----------(Fold Here) ----------(Fold Here) ----------

Return Address:

_____

_____

_____

Cecil County Department of Emergency Services

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