OMB 0920-0008

62134

Hurricane Evacuee Medical Intake Form (v.4)

ID

Complete one form for each individual. Please print in BLOCK

1. City of Departure

2. State of Departure

3. Date of Departure
Month (01-12) Day (01-31)

4. City of Arrival

5. State of Arrival

6. Date of Arrival
Month (01-12) Day (01-31)

7. Original City of Displacement (if different from departure city)

8. Original Displacement State (if different)

9. Date of Birth
Month (01-12) Day (01-31) YYYY

10. Unaccompanied Minor (check one)
☐ Yes ☐ No ☐ Not Applicable

11. Gender
☐ Male ☐ Female

12. Family Name (Last)

13. Given Name (First)

14. Middle Initial

15. Permanent Home Address

16. City

17. State/Province

18. Country

19. Postal Code

20. Permanent Home Telephone

21. Mobile Phone or Pager

22. E-mail Address

23. Do you have an intended place to go for shelter? ☐ Yes ☐ No ☐ Unknown

24. If YES, Facility Name or Hotel Name

25. Street Address (if known)

26. Telephone/Mobile Phone/Pager (if known)

27. City

28. State

29. Postal Code (if known)

Emergency contact information - to give or receive critical health information.

30. Telephone/Mobile Phone/Pager

31. Contact Person Name

32. City

33. State/Province

34. Country

Date of intake: ___/____/____ (mo/day/year)

Hurricane Katrina Evacuee Medical Intake Form

Age: _____ ☐years ☐months ☐days

Facility Name: _____

Gender: ☐ Male ☐ Female

Facility City: _____

Spanish or Hispanic or Latino Ethnicity*: ☐ Yes ☐ No

Facility State: _____

Race (choose one or more) *:

Facility Phone: _____

☐White ☐Black, African American, or Negro

☐American Indian or Alaska Native. Print name of enrolled or principal tribe_____

☐Asian --☐Native Hawaiian --☐Other Pacific Islander --☐Some other race

*To be chosen by evacuee

Language spoken at home most of the time: _____ (e.g., English, French, Creole, Spanish, Chinese, Korean, Vietnamese, etc)

Does the person have a history of receiving one or more means-tested federal benefits (e.g., Medicaid, food stamps, subsidized housing, etc.):

☐Yes ☐No

Does the person have: (check all that apply)

☐Gastrointestinal illness

- ☐ Watery Diarrhea (3 or more watery bowel movements per day)
- ☐ Bloody Diarrhea
- ☐ Vomiting (One episode or more)
- ☐ Other, specify _____

☐Respiratory illness

- ☐ Upper respiratory (e.g. pharyngitis) or influenza-like illness (fever and either cough or sore throat)
- ☐ Lower respiratory tract illness (e.g. pneumonia, bronchiolitis)
- ☐ Tuberculosis, suspected (cough for ≥3 weeks, fevers/chills, night sweats, or recent weight loss)
- ☐ Pertussis, suspected
- ☐ Other, specify _____

☐Neurologic illness

- ☐ Meningitis/encephalitis, suspected (fever, mental status change, focal neurologic deficits)
- ☐ Other, specify _____

☐Dermatologic condition

- ☐ Varicella, suspected (vesicular rash)
- ☐ Rubella/Measles, suspected (maculopapular rash)
- ☐ Scabies
- ☐ Rash, acute onset + fever
- ☐ Other, specify _____

☐Other infectious disease condition

- ☐ Fever >100.4° F (38° C) ALONE without localizing signs
- ☐ Jaundice (Viral hepatitis, suspected)
- ☐ Lice
- ☐ Wound infection, specify site _____
- ☐ Conjunctivitis (red eyes, ocular discharge)
- ☐ Other _____

☐ Mental Health condition
- ☐ Anxiety /Depression/ Insomnia
- ☐ Substance Abuse / withdrawal
- ☐ Disorientation/Confusion
- ☐ Acute psychosis/ Suicidal or Homicidal
- ☐ Violent Behavior
- ☐ Other, specify _____

☐ Injury
- ☐ Self-inflicted Injury - Intentional (violence)
- ☐ Assault-related injury – Intentional (violence)
- ☐ Unintentional injury (accidents)
- ☐ Heat related injury
- ☐ Other, specify _____

☐ Dehydration

☐ Are you or do you think you could be pregnant? ☐ Yes ☐ No ☐ Not sure

If yes, what is your due date? ___/___/___ (MM/DD/YY) OR
when was your last menstrual period? ___/___/___ (MM/DD/YY)
If unsure, when was your last menstrual period? ___/___/___ (MM/DD/YY)

☐ Chronic Medical Conditions
- ☐ Cardiac
  - ☐ Hypertension
  - ☐ Other, specify _____
- ☐ Pulmonary
  - ☐ Chronic obstructive pulmonary disease (COPD)
  - ☐ Asthma
  - ☐ Other, specify _____
- ☐ Kidney Disease
  - ☐ Dialysis dependent
  - ☐ Other, specify _____
- ☐ Diabetes
  - ☐ Insulin
  - ☐ Oral medication
  - ☐ Other, specify _____
- ☐ Immunocompromised condition (cancer, chemotherapy, high-dose or steroid use > 2 weeks, HIV/AIDS)
- ☐ Hereditary blood disorders
  - ☐ Requires blood products
  - ☐ Other, specify _____

☐ Medications (if yes, please fill out page 4)

☐ Known Allergies, specify _____

- ☐ Person with Disabilities
  - ☐ Physical disability
    - ☐ Mobility impairment (wheelchair, walker, etc.)
    - ☐ Other, specify _____
  - ☐ Sensory disability
    - ☐ Visually impaired (blindness, limited vision)
    - ☐ Hearing impaired
    - ☐ Other, specify _____
  - ☐ Cognitive disability
    - ☐ Mental retardation
    - ☐ Autism
    - ☐ Attention Deficit Hyperactivity Disorder
    - ☐ Other, specify _____
  - ☐ Resided in a group home, nursing home or assisted care facility
  - ☐ Other, specify _____

Disposition:

- ☐ Referred for additional medical follow-up

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MEDICATIONS:

☐ Under treatment for tuberculosis at time of displacement

Name of Medication*	Dose	Frequency	Has medication? (Yes/No)	Has supply for ? days (enter number of days)	Requires medication immediately? (Yes/No)	Requires prescription refill? (Yes/No)

*If medication name unknown fill in purpose of medication (e.g., blood pressure med)