CAUTION: POSSIBLE COVID-19 CASE

Patient Summary for Person with Access and Functional Needs

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

I am a person with access and funtional needs. My parent/guardian or primary care provider believes I am showing signs of COVID-19. If I am alone, please refer to the information provided here and call my family member, guardian or service provider for clarification.

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 Provider (DSP)		DSP Phone/Email	
Other (please specify)		Other Phone/Email	
Preferred Language:			

Current Symptoms / Risk Factors

Current COVID-19 Sympton	When Did It Start?	Patient's COVID-19 Severity Risk Factors (check all that apply):	
Temp Over 100°F		Age of 60 or Older	Down's Syndrome
Dry Cough		Bowel Disease	Hypertension
Fatigue		Cancer	New Chest Pain
Shortness of Breath		Cerebral Palsy	Paralysis
Bloodshot Eyes		Chemotherapy	Recurrent Pneumonia
Diarrhea		Chronic Heart Disease	Severe Scoliosis
Loss of Sense of Smell/Taste		Chronic Lung Disease	Other: (please specify)
Other: (please specify)		Diabetes	
			Other: (please specify)
Other: (please specify)			
		On Prednisone, Dexamethasone, or any medication ending in the letters "-ab"	

Medications

Medication Name	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:

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 order'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	Needs Total Assistance
Communication:	Talkative	Limited Speech	Non-Verbal/Uses Device
Social Preference:	Social	Not Social	Varies
Sleep Schedule:	Typical	Inverted	Intermittent/Variable

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:	

Individuals with Autism

- may not experience pain in the same way
- best to observe their behaviors
- may be able to tell you their hurt/pain
- 'Hurt' is preferred word to describe pain
- verbally describing hurt/pain is preferred
- may be able to locate hurt/pain on body
- facial expressions often don't match pain
- use as few words as possible, to-the-point

PATIENT HAS MASK/FACE SENSITIVITY	No Yes If yes, please specify

PATIENT HAS GENERAL TOUCH SENSITIVTY	No Yes If yes, please specify

Additional Notes:

Adapated from the Patient Summary form created and distributed by the Ohio Association of County Boards of DD