

# 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                              |                        |  |                    |
|---|------------------------|--|--------------------|
| <b>First Name:</b>                                | <b>Middle Initial:</b> | <b>Last Name:</b>                        | <b>DOB or Age:</b> |
| <b>Address:</b>                                   |                        | <b>City, State, ZIP:</b>                 |                    |
| <b>Name of Parent/Guardian:</b>                   |                        | <b>Parent/Guardian Phone/Email:</b>      |                    |
| <b>Name of Direct Support Professional (DSP):</b> |                        | <b>DSP Phone/Email:</b>                  |                    |
| <b>County Board of DD Contact:</b>                |                        | <b>County Board Contact Phone/Email:</b> |                    |

| CURRENT SYMPTOMS / RISK FACTORS   |                    |  |
|---|--------------------|--|
| Current COVID-19 Symptoms:  | When Did it Start? | Patient's COVID-19 Severity Risk Factors (check all that apply):   |
| <input type="checkbox"/> Temp. Over 100°F<br><input type="checkbox"/> Dry Cough<br><input type="checkbox"/> Malaise/Fatigue<br><input type="checkbox"/> Shortness of Breath<br><input type="checkbox"/> Bloodshot Eyes<br><input type="checkbox"/> Diarrhea<br><input type="checkbox"/> Loss of Smell/Taste<br><input type="checkbox"/> Other (please specify)<br><input type="checkbox"/> Other (please specify) |                    | <div style="display: flex; flex-wrap: wrap;"> <div style="width: 50%;"> <input type="checkbox"/> Age 60 or Older<br/> <input type="checkbox"/> Bowel Disease <small>(Chron's, Colitis, or Similar)</small><br/> <input type="checkbox"/> Cancer <small>(Current or Previous)</small><br/> <input type="checkbox"/> Cerebral Palsy<br/> <input type="checkbox"/> Chemotherapy<br/> <input type="checkbox"/> Chronic Heart Disease<br/> <input type="checkbox"/> Chronic Lung Disease <small>(Asthma or Similar)</small><br/> <input type="checkbox"/> Diabetes<br/> <input type="checkbox"/> On Prednisone, Dexamethasone, or any medication ending in the letters "-ab"             </div> <div style="width: 50%;"> <input type="checkbox"/> Down's Syndrome<br/> <input type="checkbox"/> Hypertension<br/> <input type="checkbox"/> New Chest Pain<br/> <input type="checkbox"/> Paralysis <small>(Due to Any Cause)</small><br/> <input type="checkbox"/> Recurrent Pneumonia<br/> <input type="checkbox"/> Severe Scoliosis<br/> <input type="checkbox"/> Other:<br/> <input type="checkbox"/> Other:             </div> </div> |

| MEDICATIONS |   |                   |  |
|-------------|---|-------------------|--|
| Medication: | New Medication:<br><small>(added within the last 2 weeks)</small> | Dosage/Frequency: | Preferred Form:<br><small>(liquid, pill, etc.)</small> |
|             | <input type="checkbox"/>  |                   |  |
|             | <input type="checkbox"/>  |                   |  |
|             | <input type="checkbox"/>  |                   |  |
|             | <input type="checkbox"/>  |                   |  |
|             | <input type="checkbox"/>  |                   |  |
|             | <input type="checkbox"/>  |                   |  |

*(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 |                                      |   |   |
|---------------------------|--------------------------------------|---|---|
| <b>Bathroom Use:</b>      | <input type="checkbox"/> Independent | <input type="checkbox"/> Needs Assistance | <input type="checkbox"/> Needs Total Assistance |
| <b>Eating:</b>            | <input type="checkbox"/> Independent | <input type="checkbox"/> Needs Assistance | <input type="checkbox"/> Needs Total Assistance |
| <b>Mobility:</b>          | <input type="checkbox"/> Independent | <input type="checkbox"/> Needs Assistance | <input type="checkbox"/> Uses Assistive Device  |
| <b>Communication:</b>     | <input type="checkbox"/> Talkative   | <input type="checkbox"/> Limited Speech   | <input type="checkbox"/> Non-Verbal/Uses Device |
| <b>Social Preference:</b> | <input type="checkbox"/> Social      | <input type="checkbox"/> Not Social       | <input type="checkbox"/> Varies                 |
| <b>Sleep Schedule:</b>    | <input type="checkbox"/> Typical     | <input type="checkbox"/> Inverted         | <input type="checkbox"/> Intermittent/Variable  |

**ADDITIONAL NOTES:**

| PATIENT'S SELF EXPRESSION, LIKES, AND DISLIKES: |  |
|---|--|
| <b>I express myself by:</b>                     |  |
| <b>I calm myself by:</b>                        |  |
| <b>When I'm happy, I:</b>                       |  |
| <b>When I'm sad, I:</b>                         |  |
| <b>When I'm scared, I:</b>                      |  |
| <b>When I'm angry, I:</b>                       |  |
| <b>My likes:</b>                                |  |
| <b>My dislikes:</b>                             |  |

**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

To download this form, visit [www.oacbdd.org/covidform](http://www.oacbdd.org/covidform)

*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.*

