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?**	**Patient's COVID-19 Severity Risk Factors (check all that apply):**	
☐ Temp. Over 100°F		☐ Age 60 or Older	☐ Down's Syndrome
☐ Dry Cough		☐ Bowel Disease (Chron's, Colitis, or Similar)	☐ Hypertension
☐ Malaise/Fatigue		☐ Cancer (Current or Previous)	☐ New Chest Pain
☐ Shortness of Breath		☐ Cerebral Palsy	☐ Paralysis (Due to Any Cause)
☐ Bloodshot Eyes		☐ Chemotherapy	☐ Recurrent Pneumonia
☐ Diarrhea		☐ Chronic Heart Disease	☐ Severe Scoliosis
☐ Loss of Smell/Taste		☐ Chronic Lung Disease (Asthma or Similar)	☐ Other:
☐ Other (please specify)		☐ Diabetes	☐ Other:
☐ Other (please specify)		☐ On Prednisone, Dexamethasone, or any medication ending in the letters "-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

To download this form, visit 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.

OACB Serving People with Developmental Disabilities

Right Care Now Project