

**PATIENT/CLIENT EVACUATION PLANNING:
A Tool for Emergency Preparedness**

Healthcare Agency Name: _____

This is a tool to help home health, hospice and other agencies assist their patients/clients in developing an appropriate emergency evacuation plan. Pursuant to HIPAA statutes, some information in this document may be confidential and handled as HIPAA and other privacy law require. Medical Needs Shelters do NOT provide medical care so this will not be a good option for sheltering someone receiving home care. **Please do not send this document back to DHEC. This document is strictly designed to help caseworkers and healthcare providers develop evacuation and sheltering plans for patients**

A. PATIENT/CLIENT INFORMATION:

Today's Date: _____

Name: _____
Last First MI

Sex (Circle): Male Female

Street Address: _____
Street City State Zip

Mailing Address (if different from above) _____

Date of Birth: _____ Age: _____ Telephone: _____ Cell Phone: _____

Work Phone: _____ Other Phone: _____

Is English Your Preferred Language (Circle): Yes No If No, Your Preferred Language: _____

Living Situation (Circle): Living Alone With Spouse With Spouse & Child(ren) With Parents
With Other Relative With Non-Relative With Child(ren) Service Animal Pets

B. EMERGENCY CONTACTS:

Contact: _____ Relationship: _____ Telephone: _____

Agency Caseworker (Primary): _____ (Other): _____

Telephone: _____ Cell phone: _____ Work phone: _____

Person Completing This Form (if different from above) _____

Address/Company _____

C. DURING A DISASTER I PLAN TO:

- Stay with a Relative/Friend in the Area
- Stay in Residence
- Stay with a Relative/Friend Outside the Area
- Other Plans (describe): _____
- As a Last Resort:** Go to a Shelter (Caseworker can help determine other shelter needs)

D. ASSISTANCE REQUIRED:

Do You Anticipate Needing the Assistance of Another Person? (Circle) Yes No

If So, Do You Have a Caregiver That Could Go with You? (Circle) Yes No

If Yes, Name: _____ Relationship: _____

Telephone: _____ Cell Phone: _____ Work Phone: _____

Transportation Plan: Car Taxi Bus Van Ambulance

Name of Transportation Company or Family Member and Telephone Number: _____

Note: Inability to ride in a car, taxi, bus, or van requires transportation by ambulance. If you require special/ambulance transportation and/or a hospital, you must make those arrangements yourself.

PATIENT/CLIENT EVACUATION PLANNING: A TOOL FOR EMERGENCY PREPAREDNESS

Patient/Client Name: _____

Page 2

E. MEDICAL CARE INFORMATION: (Circle those that apply)

Memory Impaired
Speech Impaired
Sight Impaired
Hearing Impaired
Mobility Impaired
Walker/Cane
Wheelchair, Manual
Wheelchair/Scooter, Powered
Other: _____
Mental Health Impaired
Describe: _____
Alcohol/Substance/Tobacco Use or Dependence
Insulin Dependent
Insulin Self-Administered: Yes or No
Open Wounds
Incontinence
Obesity – Weight
Service Animal: _____
Bedridden:

Oxygen Dependent, Portable
Oxygen Supplier and Phone Number: _____
Dependent Upon Electrically Energized Equipment
Electrical Equipment Required:
Nebulizer
Respirator Dependent
Details: _____
Oxygen Concentrator
Dialysis Dependent
Hemodialysis
Peritoneal Dialysis
Dialysis, Portable
Other Electrical Equipment Required:

Other (any information that is critical to the overall care of the patient/client):

If so, height & weight: _____

Allergies and/or Special Diet: _____

Medications/Dosages: _____

Primary Physician Name: _____ Telephone: _____

Pharmacy Name: _____ Telephone: _____

Health Insurance Company Name: _____ Telephone: _____

Please do not send this back to DHEC. This document is strictly designed to help caseworkers and healthcare providers develop evacuation and sheltering plans for patients

Instructions for Completing DHEC Form 0548

PATIENT/CLIENT EVACUATION PLANNING: A TOOL FOR EMERGENCY PREPAREDNESS

PURPOSE:

Emergency preparedness, response, and recovery begin at the individual level. The best way to prevent injury and loss of life during an emergency evacuation is advance planning that prepares the individual for such an event. Experience shows that without proper planning and community preparedness, disasters become even more chaotic and unnecessary loss of life and injuries result. In short, individuals may face increased risk, higher death rates, and difficulty in evacuating without prior planning at both the household and agency levels.

Prior to, during, or after a disaster, there is often a need to establish areas of safe refuge or shelters to temporarily house those who are displaced as a result of a disaster. It is essential to be prepared to shelter or provide safe refuge during an emergency or disaster to all individuals within a community who do not have an alternative such as friends and family. The management of nursing, convalescent, retirement and other group facilities are responsible for the evacuation and sheltering of their own residents. **Note: Medical Needs Shelters do not provide actual medical care, but do traditionally provide amenities such as back-up power for those who are dependent on medical devices..**

INSTRUCTIONS:

This is a tool to help home health, hospice and other agencies assist their patients/clients in developing an appropriate emergency evacuation plan. This document, if it's an electronic PDF, can be filled out on your computer.

This form should be completed by the patient/client, their responsible party (local family member, friend, legally authorized individual, etc.), or the current healthcare provider, and reviewed annually and updated at the time of an impending hurricane.

Complete all sections of the evacuation information form. Be sure to indicate all "yes or no" choice questions. If more than one person in your household needs assistance during evacuations, each one must complete a separate form. The patient or their responsible party must sign the evacuation information form.

Section A. Please complete the requested Patient/Client information.

Section B. Please complete the requested Emergency Contacts for the Patient/Client.

Section C. Please show where a Patient/Client is planning to stay during a disaster or emergency event.

Section D. Any anticipated assistance that the Patient/Client requires for emergency planning should be indicated here.

Section E. Please enter specific medical care information about the Patient/Client; be as detailed as necessary.

Please do not send this back to DHEC. This document is strictly designed to help caseworkers and healthcare providers develop evacuation and sheltering plans for patients