



Special Medical Needs Voluntary Registration

Pitt County Emergency Management has developed a computerized registry of people with special medical needs who may require special assistance in the event of a disaster, such as a hurricane, tornado, severe storm, or chemical spill.

Special Needs Include the Following:

- Individuals with severe respiratory problems (Oxygen or ventilator dependent) who require a power source and/or ambu bag.
- Individuals dependent on airway suctioning (tracheotomy).
- Individuals on IV (intravenous) therapy.
- Individuals requiring tube feeding.
- Diabetic patients requiring assistance with insulin.
- Individuals requiring wound care or help with injections on a daily basis.
- Individuals with physical or mental conditions, including traumatic brain injury, who require daily medical supervision.

Assistance dogs are allowed in Special Medical Needs Shelters; however, individuals are responsible for care of the dog, including bringing food and other essentials. Pets are not allowed in shelters.

Individuals who come to a Special Medical Needs Shelter are responsible for bringing a five (5) day supply or medications, medical supplies, and any other items needed to meet their needs.

This is a voluntary registration. The information you provide will be confidential in accordance with state law. It will be used by emergency personnel only to assure your safety in the event of a disaster. You may need to be evacuated to safety, or you may need to stay within your home with special assistance. Should you wish to be included in the registry, **please complete the tear-off questionnaire and return it to REAL Crisis Center.** If you have questions, call **REAL CRISIS CENTER.**

If you know of someone else who might need disaster assistance, please share this information with them.

Sponsored by

Pitt County Emergency Management
1717 W. 5th Street
Greenville NC 27834
(252) 902-3950

Pitt Aging Coalition
Pitt County Council on Aging
P O Box 7272
(252) 752-1717

REAL Crisis Center
600 E. 11th Street
Greenville NC 27858
(252) 758-HELP

**DIRECT ALL
INQUIRES TO
REAL CRISIS.**

After completing this form detach and return to: **REAL CRISIS** (see address at bottom of the left side).

Name: _____ Date of Birth _____
 Your Physical Street Address: _____
 City: _____ Zip: _____ Phone: _____
 Your Mailing Address: _____
 Caregiver: _____ Phone: (h) _____ (w) _____
 Emergency Contact Person: _____ Phone: (h) _____ (w) _____
 Primary Language: _____ **TDD/TTY (for hearing impaired)** Yes _____ No _____
 Primary Physician: _____ Physician's Phone: _____
 Home Health Care Provider: _____ HHC Phone: _____
 Pharmacist: _____ Pharmacist Phone: _____

SPECIAL MEDICAL NEEDS: Circle all medical needs that apply to you as defined by the categories listed in the information on the left.

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| | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
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- What is your primary disaster plan?**
 _____ 1. Stay with family or others: If so, name, address, phone #: _____
 _____ 2. Stay at home _____ Do you have a generator? _____
 _____ 3. Evacuate to a shelter (A caregiver must accompany you to the shelter and stay with you) _____
- Do you have transportation to a shelter?** _____ YES _____ NO
If No, what are your transportation needs? _____ Car _____ Van with lift _____ Ambulance
- Do you need assistance with walking?** _____ Walks Unassisted _____ Walks with Assistance
 _____ Wheelchair _____ Bed Bound
- Disabilities**
 _____ Hearing Impaired _____ Sight Impaired _____ Speech Impaired _____ Contagious Disease
 _____ Assistance Dog (such as guide dog) Other: _____
- Do you presently live in:** _____ Apartment _____ House _____ Mobile Home
- Do you have medical equipment that requires power?** _____ Yes _____ No
- Do you have a living will?** _____ Yes _____ No
- Medical Needs**
 _____ Life Support _____ Dialysis _____ (frequency)
 _____ Feeding Tube _____ IV Fluids _____ (frequency)
 _____ Insulin (self) _____ Suction Unit _____ (frequency)
 _____ Insulin (with assistance) _____ Special Diet (describe) _____
 _____ Ventilator _____ Oxygen _____ Hours per day
 _____ Wound Care _____ (frequency) _____ Portable Oxygen Tank
 _____ 24 hour caregiver _____ Concentrator (for oxygen)
 _____ Colostomy (self) _____ **Oxygen Provider:** _____
 _____ Colostomy (with assistance) _____ Other: _____
 _____ Ileostomy (self) _____
 _____ Ileostomy (with assistance) _____
- Do you have equipment or supplies that you cannot transport?** _____ If yes, please list: _____

I certify that the above information is correct. I understand that I am responsible for all expenses associated with medical evacuation and shelter at a hospital. In the event of an emergency, I hereby authorize Pitt County Emergency Management to release, use or disclose this information to other emergency response or human services agencies or officials. I also give law enforcement permission to enter my home in case of an emergency. I understand I have the right to revoke this authorization as outlined by the Pitt County Notice of Private Practices.

Signature _____ Date _____
rev. 5/08

