

TAB C

Patient Disaster Plan Identification Form

Name of Parish:	_____
Name of Agency:	_____
Address:	_____
Phone:	_____ State License #: _____
Filled out by:	_____ Date: _____

Instructions: The Disaster Plan ID Form should be completed for each patient upon admission. The information should be kept current. The form should be placed in the medical records of the patient and a copy provided to all patients. For Category II patients requiring community assistance, please attach a copy of the completed Disaster ID form to Tab A - Section 3.

Patient Condition: Category I-HA ___ Category I-HS ___ Category II ___
Definitions of Categories can be found in Tab A and in the Model Home Health Plan

Patient Name: _____ **SSN:** _____ **Age:** ___ **Sex:** ___
Address: _____ **Phone:** _____
_____ **Alternate Phone:** _____
Cross Street: _____ **House:** ___ **Mobile Unit:** ___ **Apartment:** ___
Complex/ Mobile Home Park Name: _____ **Apartment/Lot:** _____

Primary Caregiver: _____ **Phone:** _____
Next of Kin: _____ **Phone:** _____
Address: _____

Primary Physician: _____ **Phone:** _____
DME in use: _____
Supplier: _____ **Phone:** _____
Supplies: _____
Pharmacy: _____ **Phone:** _____

I give permission for emergency/law enforcement personnel to enter my home to assist me with evacuating. _____ Yes _____ No

I grant permission to medical providers, transportation providers, and other care providers as necessary, to provide care and disclose any information necessary to respond to my needs.
_____ Yes _____ No

PHYSICIAN'S AUTHORIZATION:

This patient may be transferred via (car/van/bus/ambulance) in the event evacuation becomes necessary.

Physician Signature

Date