Health Summary for People with Disabilities

Possible Case of COVID-19

First Name:	Middle Initial:	Last Name:	DOB or Age:

Emergency Contact:	Phone Number:	Relationship:

PERSON HAS A SUPPORTED DECISION MAKING DESIGNEE or GUARDIAN ☐ YES ☐ NO

PERSON HAS A LIVING WILL/POWER of ATTORNEY of HEALTHCARE ☐ YES ☐ NO

PERSONAL INFORMATION

Address:	City, State, ZIP:
Name of Family Member/Supporter/Guardian:	Family Member/Supporter/Guardian Phone/Email:
Name of Caregiver/Support Professional:	Caregiver/Support Professional Phone:
Managed Care Organization (MCO) Care Manager or IRIS Consultant :	MCO Care Manager Phone/Email:

CURRENT SYMPTOMS / RISK FACTORS

COVID-19 Symptoms:	When Did it Start?	Patient's COVID-19 Severity Risk Factors (check all that apply):			
Temp. Over 100°F		Hypertension	☐	Diabetes	☐
Cough		Immunocompromised	☐	Other:	☐
Fatigue		Cancer	☐	Other:	☐
Shortness of Breath		Chronic Lung Disease	☐	Other:	☐
Sore Throat		Chronic Kidney Disease	☐		
Diarrhea		Chronic Liver Disease	☐		
Muscles Aches		Seizure Disorder	☐		
Chills		Heart Disease	☐		
Headache		Hypertension	☐		
Nausea		Bowel Disease	☐		

MEDICATIONS

Medication:	Dosage/Frequency:

ALLERGIES

To What:			Symptoms of Allergy
Latex Allergy:	☐ Yes	☐ No	

Important Information to Know About Me

I am a person with a disability. I am showing signs of COVID-10 infection. If I cannot communicate with you and my family or my caregiver is not with me, these are some important things to know about me.

ACCOMMODATIONS:		SPECIALIZED EQUIPMENT:	
Language Interpreter	☐	Manual Wheelchair	☐
ASL Interpreter	☐	Power Wheelchair	☐
Personal Assistant	☐	Walker/Cane	☐
Communication Device	☐	Hearing Aids	☐
Service Animal	☐	Communication Device	☐
Extra time to understand	☐	CPAP/BI-PAP	☐
Read to me	☐	Other:	
Simple Language	☐	Other:	
Other:		Other:	
Other:		Other:	

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:	

I am sensitive to or do not like touch. ☐ **Yes** ☐ **No** **Notes:**

I am sensitive to or do not like masks. ☐ **Yes** ☐ **No** **Notes:**

Additional Notes:

This form has been created and distributed by the Ohio Association of County Boards of DD with substantial input and guidance from Susan Abend of the Right Care Now Project. The Wisconsin Board for People with Developmental Disabilities adapted for use in Wisconsin.

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