



**CONTACTS AND EVACUEES**

PSN Applicant Name: \_\_\_\_\_

\_\_\_\_\_(\_\_\_\_\_)\_\_\_\_\_  
Primary Doctor: Phone

\_\_\_\_\_(\_\_\_\_\_)\_\_\_\_\_  
Home Health Agency Info Phone:

\_\_\_\_\_(\_\_\_\_\_)\_\_\_\_\_  
Emergency Contact Phone

\_\_\_\_\_(\_\_\_\_\_)\_\_\_\_\_  
Caregiver Phone

\_\_\_ Evacuate Spouse?  
\_\_\_ Evacuate Caregiver?

\_\_\_ Number of additional Evacuees (Excluding PSN Spouse, Caregiver)

**MEDICAL INFORMATION**

- \_\_\_ Aphasia
- \_\_\_ Arthritis
- \_\_\_ Asthma
- \_\_\_ Breathing Treatment
- \_\_\_ Bronchitis
- \_\_\_ Cancer
- \_\_\_ Cerebral Palsy
- \_\_\_ Comatose
- \_\_\_ Contagious Disease – Type: \_\_\_\_\_
- \_\_\_ Dementia \_\_\_ Early \_\_\_ Moderate \_\_\_ Late
- \_\_\_ Diabetes
- \_\_\_ Dialysis: (In Home Dialysis?) \_\_\_ Yes \_\_\_ No
- \_\_\_ Difficulty Speaking
- \_\_\_ Edema
- \_\_\_ Emphysema/COPD
- \_\_\_ Hearing Impaired
- \_\_\_ Heart Condition \_\_\_ Stable \_\_\_ Unstable
- \_\_\_ High Blood Pressure
- \_\_\_ Hip/Knee Replacement: When? \_\_\_\_\_
- \_\_\_ Hospice

- \_\_\_ Medical Equipment. Circle any that apply:  
(Feeding tube, Ventilator, IV, Indwelling Catheter)
- \_\_\_ Memory Loss
- \_\_\_ Mentally Impaired
- \_\_\_ Multiple Sclerosis
- \_\_\_ Muscular Dystrophy
- \_\_\_ Nebulizer
- \_\_\_ Open Sores
- \_\_\_ Ostomy – Type \_\_\_\_\_
- \_\_\_ Oxygen Use \_\_\_ LPM (Number on dial)
- \_\_\_ Parkinson’s Disease: \_\_\_ Early \_\_\_ Mod \_\_\_ Late
- \_\_\_ Psychosis \_\_\_ Controlled \_\_\_ Uncontrolled
- \_\_\_ Seizures \_\_\_ Controlled \_\_\_ Uncontrolled
- \_\_\_ Sight Impaired
- \_\_\_ Skin Disease
- \_\_\_ Skin Infections
- \_\_\_ Special Diet (Bring doctor-prescribed food)
- \_\_\_ Speech Impaired
- \_\_\_ Stroke/CVA (Limitations)

List known allergies: \_\_\_\_\_

List medication: \_\_\_\_\_

Other Comments: \_\_\_\_\_

**POWER DEPENDENT**

- \_\_\_ Electric Dependent, Why? \_\_\_\_\_
- \_\_\_ Oxygen Concentrator
- \_\_\_ Sleep Apnea (CPAP Machine)
- \_\_\_ Ventilator/Respirator (Machine is used to breath for you, unlike the Oxygen Concentrator and CPAP)
- \_\_\_ Other, Please Specify: \_\_\_\_\_

**MOBILITY**

- \_\_\_ I have someone assist me with all my daily activities
- \_\_\_ I walk without help
- \_\_\_ I use a cane
- \_\_\_ I use a walker. Walk long distances? \_\_\_ Yes \_\_\_ No
- \_\_\_ I use a wheelchair
- \_\_\_ I am bedridden

**\* ALWAYS CONTACT EMERGENCY MANAGEMENT WITH CHANGES TO YOUR APPLICATION.**