COVID-19 DISABILITY FORM

Please answer the questions on this form to help physicians provide you with proper medical treatment, in case you need to go to the hospital for COVID-19 related symptoms. Complete as many of the questions as possible.

What is your name? _____

1. **Is this form being completed by someone else other than you?** ❑ yes ❑ no

   1.a. If yes, please select from the following options. If no, please continue to 2.

❑ legal guardian ❑ aide or staff member ❑ family member ❑ other

→What is the person's name _____ Relationship to you _____

2. **Who can we talk to about medical issues if you can't answer questions?**

→What is the person's name _____ Phone number _____

3. **I am my own decision maker/no guardian:** ❑ yes ❑ no

4. **Do you have the following?**

❑ guardian ❑ health care surrogate ❑ medical power of attorney ❑ Supported Decision Making Team

→What is the person's name _____ Phone number _____

5. **Do you have the following? If so, please remember to take a copy to hospital.**

❑ Living Will ❑ Medical Orders for Scope of Treatment "MOST" Form ❑ Advanced Directive

6. **If you don't have any of the above items, while you are in the hospital you can't breathe on your own, do you want a machine to help breathe for you?** (Mechanical ventilation)

❑ Yes, I want it as long as it's needed. ❑ Yes, I want to see if it will help ❑ No, not at all

7. **If while you are in the hospital your heart stops, do you want your doctor to try to restart it with pushing on your chest, medications, and electric shocks?** (Resuscitation) ❑ yes ❑ no

8. **If you can't eat or drink like you normally do, do you want liquid food and water to be given to you through a tube to your stomach or in a vein?** (Artificial nutrition/hydration) ❑ yes ❑ no

9. **Who do you trust to make medical decisions if you aren't able to, if different from above?**

→What is the person's name _____ Phone number _____

10. **Do you receive or have you received services like PCAP, SGF, Michelle P., or SCL waivers? (Medicaid waivers for people with intellectual and/or developmental disabilities, which support people in the community through person centered team process)** ❑ yes ❑ no ❑I don't know

11. **Do you need anything to help you communicate?** (example: assistive devices) ❑ yes ❑ no

    11.a. If yes, please describe: _____

12. How do you communicate best? Check all that apply

❑ Talking ❑ Pictures ❑Pointing to words
❑ Writing or typing words ❑Using Sign Language ❑Using Sign Language
❑ Using voice app
❑ I cannot communicate in a way you will understand, please ask my family, staff or guardian.
❑ Other: _____

13. Does anyone help you communicate? ❑ yes ❑ no

13.a. If yes, please list the person's name: _____

14. Do you use any assistive devices for mobility? ❑ yes ❑ no

14.a. If yes, please list the device(s): _____

15. Do you have any triggers? If answer is no, please continue to 16. ❑ yes ❑ no
(example: being touched, trauma, doctors of a particular gender, noises, lighting, smells, textures)

15.a. If yes, please describe triggers: _____

15.b. What is your response to triggers? _____

15.c. How can you best be helped when triggered? _____

16. What is your typical response to a medical exam? (please describe below)
❑ Fully/partially cooperate ❑ Fearful ❑ Aggressive ❑Resistant

16.a. I like it when health professionals: _____

16.b. I do not like it when health professionals: _____

17. Do you have medical issues that you go to the doctor's office? ❑ yes ❑ no
(example: heart disease, high blood pressure, lung, or breathing issues)

17.a. If yes, please describe_____

18. Please list the name of the doctor you would like contacted if you are at the hospital:

→What is the doctor's name _____ Phone number _____

19. Do you have any of the following?
❑depression ❑ schizophrenia ❑bi-polar ❑borderline ❑anxiety

❑other: _____

20. Do you have seizures? ❑ yes ❑ no

20.a. If yes, please list the type and frequency_____

21. Do you have any challenging behaviors that we should know about?

❑ aggression ❑biting ❑pica ❑self-injurious ❑ elopement ❑ property destruction

❑other:_____

22. Are there any specific modifications that could help with? ❑ yes ❑ no

22.a. If yes, please describe_____

23. Do you take any medication(s) at home every day? ❑ yes ❑ no

23.a. If yes, please list the type below. If no, please continue to 24.

❑ Prescription: ❑ Over the Counter:

_____ _____

_____ _____

_____ _____

_____ _____

24. Do you have any allergies? ❑ yes ❑ no

24.a. If yes, please list:_____

25. Do you use tobacco? (example: cigarettes, cigars, chewing tobacco, or a vape) ❑ yes ❑ no

25.a. If yes, please list: _____ **how often?** _____

26. Do you use alcohol? ❑ yes ❑ no

26.a. If yes, how much do you use in a week? _____

27. I live (check one box)

❑ By myself ❑ With my family
❑ With roommates ❑ In a group home
❑ Supported living ❑ Nursing home
❑ Other (please describe) _____

28. Does anyone you know have COVID-19? ❑ yes ❑ no ❑I don't know

28.a. If yes, when were you told the person has COVID-19? _____

28.b. If yes, what was the last date you saw this person? _____

Kentucky DEVELOPMENTAL DISABILITIES NETWORK

Commonwealth Council on Developmental Disabilities
Kentucky Protection and Advocacy
University of Kentucky Human Development Institute

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