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? _____

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

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

If you checked yes, what is the person's name _____ Relationship to you _____

Do you receive or have you received services from the New York State Office for People with Developmental Disabilities (OPWDD) or Office for Mental Health (OMH)? ❑ yes ❑ no ❑ I don't know

****Note to doctors: This means there may be special laws in place to protect me and a special process needs to be followed if my usual decision maker/guardian requests to withhold or withdraw life sustaining treatment. Please check in with your institution's social worker or risk management department to be sure the appropriate process is being followed.*

How do you communicate best? *(check all that apply)*

❑ Talking ❑ Writing or typing things down

❑ Pictures ❑ Using sign language

❑ Pointing to words ❑ Using a voice app

❑ I cannot communicate in a way you will understand, please ask my family, staff or guardian *(circle the person)*

❑ Other *(please describe)* _____

Do you need anything to help you communicate?

(E.g. assistive devices) ❑ **no**

❑ **yes** *(please describe)* _____

Does anyone help you communicate? ❑ **no**

❑ **yes, person's name** _____

Do you use any assistive devices for mobility? ❑ **no**

❑ **yes** *list the device(s)* _____

Do you have any triggers *(e.g., being touched, trauma, doctors of a particular gender, noises, lighting, smells, textures):*

_____

What is your response to triggers?

_____

How can you best be helped when triggered?

_____

What is your typical response to a medical exam?

❑ Fully/partially cooperates ❑ Fearful

❑ ggressive ❑ Resistant

I like it when health professionals *(please describe)*

_____

I do not like it when health professionals *(please describe)*

_____

Do you have any medical problems that you go to the doctor for?

❑ yes ❑ no

What are they?

_____

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

Name _____

Phone Number _____

re there any diagnoses, medical problems or behaviors that we should consider as cautions? *(e.g., aggression, biting, pica, aspiration risk):*

_____

re there any specific modifications that could help with these cautions?

_____

Do you have seizures? ❑ **no**

❑ **yes,** *list the type and frequency* _____

_____

Do you take any medication at home every day? ❑ yes ❑ no

By prescription? ❑ **no**

❑ **yes,** *list the names and dosage* _____

_____

_____

_____

Over the counter? ❑ **no**

❑ **yes,** *list the names and dosage* _____

_____

_____

Do you have any allergies? ❑ **no**

❑ **yes,** *please list* _____

Do you use tobacco *(e.g., cigarettes, cigars, or chewing tobacco)?*

❑ yes, please list _____ how often_____

❑ no

Do you use alcohol? ❑ no

❑ yes How much do you use in a week?_____

Do you use any other drugs *(eg., marijuana, cocaine, or opiates)?*

❑ yes, please list_____

❑ no

Who can we talk to about medical problems if you can't answer questions? Name _____

Phone number _____

Who do you trust to make medical decisions if you aren't able to?

Name _____

Phone number _____

Do you have a health care agent? ❑ no

❑ **yes, Name** _____

Phone number _____

I live *(check one box):*

❑ **By myself** ❑ **With my family**

❑ **With roommates** ❑ **In a group home**

❑ **Supported living** ❑ **Nursing home**

❑ **Other** *(please describe)* _____

Does anyone you know have COVID-19? ❑ yes ❑ no

❑ I don't know

When were you told the person has COVID-19? _____

What was the last date you saw this person? _____

Capacity to consent

❑ **Capable/Own Guardian** ❑ **Substitute Decision Maker** ❑ **Supported Decision Making Team** ❑ **Guardian/Conservator**

❑ **Other,** *Please describe* _____ ❑ **How was this decided?** _____

For patients who are their own guardian/have capacity:

Do you have *(circle all)* **1) an advance directive 2) a health care agent 3) a living will 4) a MOLST form?**

If so please bring a copy of each document to the hospital

If 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)*

❑ **Do you not want it at all?**

❑ **Do you want a trial to see if it is helping?**

❑ **Do you want it for as long as it is needed?**

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**

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? *(rtificial nutrition/hydration)* ❑ **yes** ❑ **no**

Patient's Name:
Indicate: Parent Guardian Responsible Person (indicate relationship or affiliation)

Name:

Address

City, State

Telephone