

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
☐ Aggressive ☐ 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 _____

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

Are 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? (Artificial nutrition/hydration) ☐ yes ☐ no