Home Health & Hospice of Montana

PATIENT INDIVIDUALIZED EMERGENCY PLAN

Patient Name: _____ **Patient ID:** _____

DOB: ___/___/_____ ☐ **Male** ☐ **Female** **Home Phone:** _____ **Cell Phone:** _____

Address: _____

Emergency Contact Name *(out of home)*: _____

Relationship: _____ **Phone:** _____ **Alternate Phone:** _____

Address: _____

Patient Instructions: Identify a safe place and how to prepare the home to minimize damage. In the event of an emergency or disaster, take your emergency supply kit to your safe place and notify your out-of-home emergency contact of your location and condition. Contact emergency officials by calling 911 if you are injured.

Safe space in home: ☐ Winter Storm: _____ ☐ Flood/Hurricane: _____ ☐ Other: _____

Safe meeting place in neighborhood: ☐ N/A or _____

Safe meeting place outside of neighborhood: ☐ N/A or _____

Fire safety/exits: _____

Other: _____

In the event of a widespread emergency or disaster, you will be contacted for medical attention based on your priority level:

☐ **Level 1** - Within 24 hours ☐ **Level 2** - Within 24-48 hours ☐ **Level 3** - Within 48-72 hours

If evacuation is needed, notify Consumer Direct Care Network and see instructions below.

To facilitate appropriate care, transportation and/or evacuation the patient plans to:

☐ Remain in the home

☐ Evacuate to home of family member or friend with assistance of family and/or caregiver.
Name: _____ Address: _____ Phone: _____

☐ Evacuate with assistance. Consumer Direct Care Network may assist to arrange for non-emergency transportation, contact the patient's out-of-home emergency contact and help to locate an available:
☐ Motel/hotel ☐ Shelter ☐ Special needs shelter ☐ Non-emergency inpatient admission

☐ Evacuate with assistance of emergency officials. **Call 911 for emergency transportation.**

Select all special needs:

☐ Patient has restricted mobility: *(Select level of mobility)*
☐ Bedbound ☐ Chair/wheelchair bound ☐ Ambulatory with assistance: ☐ Maximum ☐ Moderate ☐ Minimum
☐ Assistive devices: ☐ Cane ☐ Walker ☐ Other: _____

☐ Patient requires lifesaving equipment: *(Select all that apply)*
☐ Insulin requiring diabetic. Insulin administered by: ☐ Injection ☐ Pump *(type: _____)*
Insulin type, dose and frequency: _____
☐ Oxygen at ____ liters/minute via: ☐ Nasal cannula ☐ Mask ☐ Tracheal ☐ Liquid ☐ Concentrator ☐ Cylinder
☐ Requires oxygen continuously ☐ Requires oxygen intermittently: hours per day: _____
☐ Portable oxygen cylinder available ☐ Portable battery-operated oxygen concentrator available ☐ **No** portable oxygen available
☐ Ventilator dependent: *(type: _____)*
Ventilator settings: Respiratory rate: _____ Tidal volume: _____ FiO_2: _____ PEEP: _____
☐ Ventilator **is** portable with back-up battery ☐ Ventilator **is not** portable
☐ CPAP: _____ cm H_2O
☐ BiPAP: IPAP: _____ cm H_2O EPAP: _____ cm H_2O
☐ BiPAP ST: IPAP: _____ cm H_2O EPAP: _____ cm H_2O Respiratory rate: _____
☐ Suction machine: ☐ Suction machine **is** portable with back-up battery ☐ Suction machine **is not** portable
☐ Infusion pump: ☐ Infusion pump **is** portable with back-up battery ☐ Infusion pump **is not** portable
☐ Enteral pump: ☐ Enteral pump **is** portable with back-up battery ☐ Enteral pump **is not** portable
☐ Apnea monitor: ☐ Apnea monitor **is** portable with back-up battery ☐ Apnea monitor **is not** portable

☐ Other medical needs:
☐ Wound care: _____
☐ Intravenous medications: _____
☐ Tube feeding: _____
☐ Other: _____

☐ Other special needs:
☐ Communication barriers: _____ ☐ Language barrier: _____
☐ Intellectual disability: _____ ☐ Special diet: _____
☐ Other: _____

_____ _____ _____
Clinician Signature/Title Date/Time Patient or Legal Representative Signature