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 Michigan Behavioral Health and Developmental Disabilities Administration?

❑ 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* _____