# 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
❑ Pictures
❑ Pointing to words
❑ Writing or typing things down
❑ Using sign language
❑ 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**