

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 Texas Health and Human Services, Intellectual and Developmental Disability Services, Star Plus, Star Kids, or Star Health? 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, psychiatric or physical problems that you go to the doctor for? yes no

What are they?

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?

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

Name _____

Phone Number _____

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 I don't know

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 _____

Do you have a Supported Decision Making Agreement? If yes, please tell us the name and phone number of your listed support person.

Name _____

Phone number _____

Do you have a health care agent or Power of Attorney? 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 Maker

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/POA 3) a living will 4) a MOST 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

We will protect your privacy. Please tell us who you want us to talk to about your care.

1. Name:

Phone:

Email:

3. Name:

Phone:

Email:

2. Name:

Phone:

Email:

4. Name:

Phone:

Email:

This document and the information therein is for general informational purposes only and should not be relied upon as a basis for any medical, legal or business decision. Any reliance placed on such information shall be at the user's own risk.

This form was adapted from one created by Stony Brook University, available at <https://you.stonybrook.edu/disabilitycovid19forms/2020/04/08/preparing-individuals-with-intellectual-developmental-disabilities-for-medical-treatment-at-hospitals/>

For assistance with your understanding and exercising your rights, please contact Disability Rights Texas. During the COVID 19 emergency, Disability Rights Texas offices are closed but our staff is still working remotely.

If you are a person with a disability in the state of Texas and you are experiencing a legal problem or are having difficulty obtaining disability services or are having your rights violated, call our intake line at 1-800-252-9108 Monday through Friday, 9:00 am to 4:00 pm, or you can apply online at any time at: intake.DRTx.org.

Individuals who are deaf or hard of hearing can call our toll-free video phone at 1-866-362-2851 or our Purple 3 video phone at (512) 271-9391.