Brooklyn, Ct. Special Needs Emergency Registry

For Brooklyn residents with disabilities, chronic conditions, and special healthcare needs

Brooklyn Emergency Management and Homeland Security Commission maintains a registry for residents with disabilities, chronic conditions, and/or special healthcare needs who live at home or in group homes. By participating in the Registry, you permit BEMHS to share your information with local and state emergency responders, such as your town fire departments. The information that you provide may help responders meet your needs during an emergency, though assistance cannot be guaranteed.

Instructions: To be included in the Registry, please fill out this form, sign it, and send it to:

BEMHS Director, 4 Wolf Den Road, P.O. Box 356, Brooklyn, CT. 06234 or place it in a sealed envelope addressed to BEMHS Director and drop it off at the Town Hall.

If you cannot fill out this form on your own, please have a family member, caregiver, or other representative complete the form and submit it on your behalf.

GENERAL INFORMATION: Fields marked with an asterisk(*) are mandatory. Please print clearly. First Name Middle Name Last Name Gender*: Μ Date of birth*: (MM/DD/YYYY) **PHYSICAL STREET ADDRESS** Street address*: Apartment unit/floor_____ City/town*: Zip code: MAILING ADDRESS IF DIFFERENT P. O. Box*:____ Apartment/unit: City/town*: State: ZIP code: **CONTACT INFORMATION (*Phone # required)** Home Phone: () Text only number: () Videophone number: () Cell Phone: () TTY:_____(__) Email: **EMERGENCY CONTACT:** Name:_____ Relationship: Phone:_____ LIVING SITUATION I live in Brooklyn (check al that apply to you): I live (check all that apply to you): Seasonally from _____(month) to:_____ _____Alone _Year-round With family/friends I live in (select one type of housing): _____With caregiver _____In a group home operated by_____ Single family house In an independent senior living facility _____Apartment _____floor Other: Other LANGUAGE: I prefer to communicate in (select one) Portuguese English _____French American Sign Language

Spanish

_____Other:_____

Oxygen concentrator Oxygen concentrator Oxygen concentrator I have battery or generator back up for this Respirator/ventilator I have battery or generator back up for this I racheostomy I have battery or generator back up for this I racheostomy I line Use walker/cane Use prosthesis (specify prosthesis): Use prosthesis (specify prosthesis): Use prosthesis (specify prosthesis): Use prosthesis (specify prosthesis): Oxformed to bed Confined to bed Red is power dependent I have battery or generator back up for this Dialysis at a clinic Dialysis at home I have battery or generator back up for this Pacemaker Defibrillator Other electrical needs: When I leave my home, I most frequently us a(n): Personal vehicle Taxi/car service When I leave my home, I most frequently us a(n): Personal vehicle Taxi/car service Wheelchair van/bus Ambulance Other: Use of hearing ald(s) Seture disorder Speech impaired Anxiety Non-verbal Bipolar disorder Oxegentively/ Schizophrenia Developmentally delayed Post-traumatic Autism spectrum disorder Stress disorder (PTSD) Alzheimer s/dementia Diabetes I use is sullin I veigh over 300 pounds Other: Other	LIFE SUPPORT SYSTEMS: (Check all that apply to you)		MOBILITY: (Check all that apply to you)
have battery or generator back up for this	Oxygen tanks	I have spares	Use a wheelchair/mobility vehicle
Respirator/ventilator	Oxygen concentrator		The vehicle is power dependent
Respirator/ventilator I have battery or generator back up for this Tracheostomy I/V line Urinary catheters Colostomy/lieostomy Feeding tube Suction tube Dialysis at a clinic Dialysis at home I have battery or generator back up for this Dialysis at home Dialysis at home Defibrillator Defibrillator Other electrical needs: None of the above SENSORY: Check all that apply to you Hard of hearing Use of hearing aid(s) Deaf None of the above Use of cochlear implant(s) COGNITIVE/PSYCHIATRIC/NEUROLOGICAL/ MUSCULAR (Check all that apply to you:) Seizure disorder Speech impaired Anxiety Non-verbal Developmentally delayed Post-traumatic Autism spectrum disorder Alzheimer's/dementia Obsessive compulsive Multiple sclerosis None of the above Other: Core brain paloxy Use a service Autism spectrum disorder Alzheimer's/dementia Obsessive compulsive Multiple sclerosis None of the above Other: Core a week Use of hearing aid(s) Deaf None of the above Depression Transportation Using the toilet Dressing/undressing Bathing/grooming Bathing/grooming I require supervision I require supervision I require supervision I receive medical treatment from a nurse/doctor at home I receive medical treatment at a healthcare facility at leas once a week Other: Use of hearing aid(s) When I leave my home, I most frequently us a(n): Personal vehicle Transfortation: Check all that apply to you) When I leave my home, I most frequently us a(n): Personal vehicle Transfortation: Condition Transportation Use of hearing aid(s) Transportation Use of hearing aid(s) Transportation Using the toilet Dressing/undressing Bathing/grooming Transforting from/to: Bed Wheelchair Transferring from	I have battery or generator back up for this		I have battery/generator back up for this
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Urinary catheters Colostomy/ileostomy Feeding tube Suction tube I have battery or generator back up for this Dialysis at a clinic Dialysis at home TRANSPORTATION: (Check all that apply to you) I have battery or generator back up for this Pacemaker Defibrillator Other electrical needs: None of the above SENSORY: Check all that apply to you Hard of hearing Use of cochlear implant(s) Deaf Doeaf None of the above Use of cochlear implant(s) COGNITIVE/PSYCHIATRIC/NEUROLOGICAL/ MUSCULAR (Check all that apply to you: Selzure disorder Depression Speech impaired Anxiety Non-verbal Developmentally delayed Anxiety Autism spectrum disorder Alzheimer's/dementia Obsessive compulsive Melchair van bed Diabetes I use insulin I receive medical treatment at a healthcare facility at leas once a week Other: Cognitively colonical week I have battery/generator back up for this Dehat power dependent I have battery/generator back up for this Dehat power dependent I have battery/generator back up for this Dhate ta play to you When I leave my home, I most frequently us a(n): Personal vehicle Taxi/car service Other: Ambulance Other: Ambulance Other: Other: Assistance REQUIRED: (Check all that apply to you) On a normal day, I require assistance with: Feeding myself Taking medication(s) Transportation Using the toilet Dressing/undressing Bathing/grooming Transferring from/to: Bed Wheelchair Transferring from/to: Bed Wheelchair I receive medical treatment from a nurse/doctor at home I receive medical treatment from a nurse/doctor at home I receive medical treatment at a healthcare facility at leas once a week	Tracheostomy		Use crutches
Colostomy/fileostomy Feeding tube Suction tube I have battery or generator back up for this Dialysis at a clinic Dialysis at a clinic Dialysis at a clinic Dialysis at a clinic Dialysis at home I have battery or generator back up for this Pacemaker Defibrillator Other electrical needs: None of the above SENSORY: Check all that apply to you Hard of hearing Use of hearing aid(s) Deaf Use of cochlear implant(s) COGNITIVE/PSYCHIATRIC/NEUROLOGICAL/ MUSCULAR (Check all that apply to you:) Seizure disorder Cognitively/ Sepech impaired Anxiety Developmentally delayed Post-traumatic Autism spectrum disorder Alzheimer's/dementia Obessive compulsive Melchair Most pack and the above Antipulation Diabetes I use insulin I receive medical treatment at a healthcare facility at least once a week Other: I have battery/generator back up for this None of the above Other: None of the above TRANSPORTATION: (Check all that apply to you) When I leave my home, I most frequently us a(n): Personal vehicle Taxi/car service Wheel leave my home, I most frequently us a(n): Personal vehicle Taxi/car service Other: Ambulance Other: Other: Assistance REQUIRED: (Check all that apply to you) On a normal day, I require assistance with: Feeding myself Taking medication(s) Transportation Transportation J raking medication(s) Transportation Dressing/undressing Bathing/grooming Transferring from/to: Bed Wheelchair I use a service animal I require supervision Other assistance: I use a service animal I receive medical treatment from a nurse/doctor at home I receive medical treatment at a healthcare facility at least once a week	IV line		Use prosthesis (specify prosthesis):
Feeding tube	Urinary catheters		Confined to bed
Suction tube	Colostomy/ileostomy		Bed is power dependent
	Feeding tube		I have battery/generator back up for this
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			Taxi/car service
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Parkinson's disorder (OCD) Other assistance: Cerebral palsyOther		· · · · · · · · · · · · · · · · · · ·	Transferring from/to:BedWheelchair
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Multiple sclerosisNone of the aboveI require supervision OTHER DISABILITIES/CONDITIONS:I use insulinI weigh over 300 poundsI weigh over 300 poundsI week Other:I use insulinI receive medical treatment at a healthcare facility at least once a week	Cerebral palsy	Other	
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I weigh over 300 pounds once a week Other:			I receive medical treatment from a nurse/doctor at home
Other:			· · · · · · · · · · · · · · · · · · ·
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Signature:
Print name:
Date:
If you are completing this form on someone's behalf, please indicate your name and relationship to that individual:

NOTE: By signing this form, I agree to permit my information to be shared with local and state emergency responders. I understand that this is a voluntary program and while Brooklyn Emergency Management and Homeland Security will share this information in order to better assist me during an emergency, they cannot

guarantee assistance in all cases.