

# 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 Montana Public Health and Human Services, Developmental Disabilities Program?  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 \_\_\_\_\_

**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 POLST 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