**Company Name**

# EMERGENCY / DISASTER PLAN FOR HOME HEALTH CARE PATIENTS

**(Keep this plan where it can be easily located)**



Date: ____________ Time: ____________

Patient: ________________________________________________ ID#: ____________________

Information obtained by: ☐ Client ☐ Caregiver If caregiver, relationship to patient: ______________________________

The Emergency Medical Service will need to know (caregiver):

Name: ________________________________________________ Phone: ____________________

Address: ________________________________________________________________

Client's Emergency Classification (check one): ☐ D1 ☐ D2 ☐ D3 ☐ D4 *(see back for instructions)*

**PATIENT'S DATA**

Allergies: ______________________________ Special needs: ______________________________

Medications: ________________________________________________________________

________________________________________________________________

Supplies/DME: ________________________________________________________________

Pharmacy/Phone: ________________________________________________________________

Doctor: ________________________________________________ Phone: ____________________

**In case of medical emergency, dial 911**

In case of nursing or related problem, call your Home Health Care agency: ______________________________

To contact your nurse directly, you may page her/him: ______________________________

Name: ________________________________________________________________

In case of emergency notify:

Name: ________________________________________________ Phone: ____________________

Address: ________________________________________________________________

In the event of a hurricane (other disaster) I will:

☐ Stay at home

☐ Stay with family. Phone: ________________________________________________

☐ Go to shelter (shelter address): ________________________________________________

☐ Go to a hospital, if medically necessary (hospital name): ______________________________

Please contact your Home Health Care agency ______________________________ for alternate service options in case of disaster.

Signature of Client: ________________________________________________ Date: ____________________

Signature of Nurse: ________________________________________________ Date: ____________________



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# GENERAL INSTRUCTIONS TO CLIENT ON USE OF THIS FORM:

This information is provided to you as a quick reference source in case any emergency occurs. Keep this document where it can easily be found. Inform others persons close to you (relative, neighbor, etc.) of its location.

1. ______________________________ has a nurse on call 24 hours a day. You can reach the nurse through ______________________________ . After office hours and on weekends an answering service will reach the nurse and he/she will return your call and come to see the client if necessary, or simply answer any questions you may have.
2. In case of a serious medical emergency, the client should be taken to the hospital. ______________________________ does not operate as an emergency service, therefore valuable time may be lost by contacting the Agency for a serious emergency such as diabetic coma, severe chest pain, unconsciousness, etc.
3. Ambulance service number is ___________.

**CLASSIFICATION**

(Please circle the correct classification for client)

**D1 – Category 1**

Clients cannot safely forgo care: highly vulnerable clients with high probability of inpatient admissions if home care is not provided; IV therapy, highly skilled wound care, with no family/caregiver, life sustaining medication or equipment.

**D 2 – Category 2**

Client whose conditi[illegible] worse[illegible] moderate level of skilled care. That should be provided that day, but could postpone visit un[illegible]tion improves. Client with untrained families/caregivers who could provide basic care in an emerge[illegible]

**D3 – Category 3**

Client who can safely forgo care or a scheduled visit including Home Health Aide visits, Clients receiving routine supervisory visits, evaluation visits. Clients with 1 or 2 visits/week, or Clients who have a competent family/caregiver.

**D4 – Category 4**

Patient who refused information, or signed the registration release form releasing the Agency from evacuation responsibilities.

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