|  |  |  |
| --- | --- | --- |
| DRO # | DRO Name | DRO Date |
| Service Delivery Site | City/County/State | CAS # |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Client Information** | | | | |
| Name (Last, First) | | | Primary Language | |
| Age | | Date of Birth | • Male • Female • Other | Veteran • Yes • No |
| Pre-Disaster Address | | | | |
| Current Address | | | | Phone # |
| Alternate Contact Name | | | | Phone # |
| Caregiver: •Home Health Provider •Parent •Spouse •Friend •None •Other: | | | | |
|  | Name: | | | Phone # |

|  |
| --- |
| **Allergies** |
| *List all medication, environmental, and food allergies, including type of reaction.* |
|  |
|  |
|  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Insurance Information and Medical History** | | |  | |
| Policyholder Name |  | Policy Phone # | | Policy # | |
| Health Care Provider |  | | | Provider Phone # | |
| Medical History |  | | |  | |
|  |  | | |  | |
|  |  | | |  | |
|  |  | | |  | |
|  |  | | |  | |
| Current Medication | Dosage | Last Dose | Current Medication | Dosage | Last Dose |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
| Pharmacy Name / Pho | ne # | | |  | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Primary Complaints** | | | | | | |
| *Check all complaints that apply to the current visit under each category related to the patient’s main reason(s) for seeking care. Do not record client’s medical history in this area. For follow-up visits, enter the date next to the box to update the notes section.* | | | | | | |
| Date of Injury | | **Acute Illness/Symptoms (Cont’d)** | | |  | **Care** |
|  | **Type of Injury** |                                | Heat  Cold      Res              Infl  (>1 thro Skin:          Ob         Ne  Me                  Not | Cardiac event  Fever (>100.4°F or 38°C)  -related illness symptoms  -related condition symptoms  Extreme fatigue or overexertion  Eye irritation  Dehydration symptoms Gastrointestinal: Nausea or vomiting  Diarrhea (bloody or watery) piratory  Shortness of breath/difficulty  breathing  Chest congestion  Congestion, runny nose, sinusitis  Sore throat  Wheezing in chest  Cough  uenza-like-illness (ILI) (fever of  00.4°F or 38°C and cough/sore at)    Generalized rash  Localized rash  Soft tissue infection  Fungus, ring worm, tinea stetrics/Gynecology  Vaginal bleeding outside of  pregnancy  Pregancy – abdominal cramping  Vaginal discharge  Pregnancy complications urological, specify:  ntal Health:  Behavior  Depressed mood  Anxiety or stress  Disruptive  Agitated  Suicidal or homicidal thoughts Psychotic symptoms (e.g. hallucinations, paranoia) Drug/ alcohol intoxication/ withdrawal) specified elsewhere, specify: |              | Blood pressure check  Medication refill  Blood sugar check  Immunization / vaccination Pregnancy / post-partum  assessment  Dressing change / wound care  Other |
|              | Abrasion, cut, laceration  Avulsion, amputation  Concussion  Bruise, contusion  Fracture  Sprain, strain  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | **Mechanism of Injury** | **Exacerbation of Chronic Illness** | |
|                            | Use of machinery, tools or equipment  Recreation, playing sports  Foreign body (splinter)  Ingestion of poison  Near drowning  Assault (gunshot, domestic violence)  Sexual assault or rape  Carbon monoxide exposure Hit by/against object Bite/sting:   Insect   Snake   Human   Animal (report to local public health)  Burn   Thermal (fire)   Chemical  Fall, slip, trip   Same level   From height  Motor vehicle crash   Driver/occupant   Pedestrian/bicyclist  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |                          | Asthma  Diabetes  Cancer, specify:  Renal disease / dialysis  Seizure disorder  Hypertension  Congestive heart failure  Coronary heart disease (e.g.,  MI)  Cerebrovascular disease /  stroke  Chronic joint pain (e.g., arthritis)  Obstructive pulmonary disease Previous mental health diagnosis, specify:    Other: |
| **Disposition / Record Tracking** | |
|             Ag  ( | Treated by Red Cross  Not treated by Red Cross  Refused treatment  Other    Referred   Hospital / Clinic   Pharmacy   Physician  Self-care  gregate Morbidity Form Entry list date for each visit reported) |
|  | **Acute Illness/Symptoms** |
| Pai             | n, specify if possible:  Chest Pain  Ear pain  Muscle or joint pain  Abdominal pain  Headache  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

*Intitial worker legibly prints name, signature, credentials, date, and time:*

Print Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Client Name (Last, First)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CAS # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| **Notes (at time of visit, sign each entry with a date/time, print name, signature, credentials, and position)** |
| *Legibly document initial visit and each follow-up visit. Use concise language and standard medical terms; include referral information, phone contacts, and/or services provided. Check appropriate complaints, and add a dated note next to the complaint. Document each follow-up visit on the daily Aggregate Morbidity Report Form. Disaster Health Services manager/supervisor review each Client Health Record for completeness and legible signatures before the record* is *forwarded to the disaster relief operation headquarters or chapter.* |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |