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

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| **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 #  |

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| **Allergies**  |
| *List all medication, environmental, and food allergies, including type of reaction.*  |
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|  | **Insurance Information and Medical History**  |  |
| Policyholder Name  |  | Policy Phone #  | Policy #  |
| Health Care Provider  |  | Provider Phone #  |
| Medical History  |  |  |
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| Current Medication  | Dosage  | Last Dose  | Current Medication  | Dosage  | Last Dose  |
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| Pharmacy Name / Pho | ne #  |  |

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| **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**  |                   | HeatCold  Res      Infl(>1 thro Skin:    Ob    NeMe        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 # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **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.*  |
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