Disaster Planning Toolkit for the Elderly and Special Needs Persons

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American College of Emergency Physicians

This workgroup was tasked to complete the following Objective of the 2012-2013 Disaster Preparedness and Response Committee: to develop guidelines and educational materials for disaster preparedness, including those that are unique to children, the elderly, and other groups with special needs.

The group chose to address this objective by developing a toolkit/checklist for the elderly and special needs persons to complete in preparation for a disaster and to use as a guideline in that preparation.

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Elderly/Special Needs Tool Kit for Disaster Preparation

What is this toolkit?

This form is a planning device to help you and your family prepare for many health-related needs that may arise during a disaster.

How should I/my family use this tool?

Sit down with your family members or friends and health care providers to complete the check-lists and planning activities outlined below. This form will help you complete your own personal disaster plan. Additionally, you can take it with you should you need to evacuate your residence. It can inform health care providers and others of your mobility, dietary, and medical needs.

Pre-Disaster Checklist

Consult with family members, physicians, and any health aides to complete this section

Issue	**Description / Recommendations**	**To-do**
Sheltering at Home or Residence	It is recommended that in case of a disaster you shelter in your home. Reasons to not shelter in home include: • Home uninhabitable due to flood, fire or structural damage Reasons to not shelter in home(Continued)	❑ Meet with family, friends, neighbors or health aides to determine a check-in plan to ensure your safety and to develop contingency plans in case evacuation is needed ❑ Evaluate hazards in your home needing advance repair to ensure your safety

	• Temperature of >95 F or <50F for more than 6 hours • Failure of essential medical equipment	
Alternate Sheltering Option	Should you be unable to shelter in your home, the next recommendation is the home of a friend or family member, then a shelter, special needs, elderly-care site	❑ Identify second home where you might stay. Discuss with family or friends ❑ Identify and contact nearby shelter locations (these may include nursing homes, churches, community centers)
Assistance / Contact Info	List emergency contact numbers for those who can help you evacuate. Try to also plan in advance for someone to check on you in case of a communication failure	Contact Name– Contact Telephone _____ _____ _____ _____ _____ _____
Water	The minimum recommended supply of water is 3 gallons/person/day	❑ Calculate the gallons of drinking water needed (3 / person minimum) ❑ Purchase and store required water

Food	Dry, canned or other non-perishable goods are recommended for storage for a disaster food supply along with a mechanical can opener	Consider the number of people who may be sheltering in your household ❑ Consider special dietary needs ❑ Purchase and store food reserves
Medications	It is recommended to have 2-4 weeks additional supply of regular /chronic medications	❑ Discuss with your physician, pharmacist and/or insurance about purchasing a "13th-month" supply of medications ❑ Rotate medications through so that you always have an up-to-date extra set
Sanitation Supplies	Running water and toilet facilities may be unavailable	❑ Determine waste needs ❑ Purchase sanitation supplies
Pet Supplies	If you have a pet, you must plan for their care during your sheltering process, including at home or in a separate shelter	❑ Purchase sufficient water (1 Gallon/day) and food for 3 days ❑ Purchase sanitation supplies for 3 days ❑ Inquire with your most likely shelter options about accommodations for pets or make alternate plans for their care

Disaster Checklist

Take this form with you if you should need to evacuate your residence. Have your health care provider help you complete this form

Issue	**Description**	**Checklist**
Language	Check or list your primary language and if you need an interpreter	❑ English ❑ Spanish ❑ Chinese (specify)_____ ❑ Other (specify) _____ ❑ Interpreter needed
Primary Residence	Write in your primary address:	
Family / Emergency Contact	List your primary emergency contact person and relationship	❑ Name ❑ Relationship ❑ Phone ❑ Email
Communication/ Mental Status	Please check baseline cognitive (thinking) function and communication abilities	❑ Normal conversation ❑ Slightly confused ❑ Severe confusion ❑ Nonverbal ❑ Other (describe): ❑ **Attach a recent photograph of yourself**

Mobility	Please check or list baseline mobility status	❑ Walks without assistance ❑ Walks with cane/walker ❑ Requires wheelchair/scooter ❑ Bed only ❑ Other (specify):
Activities of Daily Living	Please check or list activities with which you need assistance	❑ Walking ❑ Eating ❑ Bathing ❑ Toileting ❑ Other (specify):
Oxygen	Please list your oxygen requirement and route of delivery	❑ Oxygen method: ❑ Liters/minute:
Health Problems	Check the corresponding box or list all your health problems	❑ Attach a picture of last Electrocardiogram ❑ Attach latest Medical Record ❑ High Blood Pressure ❑ Diabetes ❑ Heart Disease ❑ Asthma / Chronic Obstructive Pulmonary Disease ❑ Memory ❑ Other(s): _____ _____

Devices/Treatments	Please check or list any ongoing treatments such as dialysis (with day requirements) and/or any implanted devices (eg pacemaker)	❑ Ventilator ❑ Peritoneal Dialysis ❑ Hemodialysis (list days) _____ ❑ Pacemaker (settings) _____ ❑ Automatic Implantable Cardioverter Defibrillator (settings) _____ ❑ Other(s):
Allergies	List your medication allergies (Or attach list)	❑ _____ ❑ _____ ❑ _____ ❑ _____ ❑ _____
Medications	List (or attach a list of) all medications and dosages including over the counter medicines If possible, bring your medications with you to any shelter (including to hospital)	❑ _____ ❑ _____ ❑ _____ ❑ _____ ❑ _____ ❑ _____ ❑ _____ ❑ _____

Palliative or Comfort Care	Please state whether you are already receiving palliative care	❑ Yes, I am receiving palliative care ❑ No/Not Applicable ❑ Name of Hospice/Contact number:
Decision Making	Please attach any forms regarding your health care proxy (medical decision maker should you be unable to speak for yourself).	❑ Healthcare Proxy Name:_____ Contact info:
Wishes regarding resuscitation	Please attach any forms regarding advance directives and summarize in the next box	❑ Full treatment and resuscitation ❑ Full treatment but <u>excluding</u> intubation or Cardiopulmonary Resuscitation(CPR) ❑ DNI (no intubation, ventilator) ❑ DNR(no CPR, chest compressions) ❑ Attach copy of: MOST(Medical Orders for Scope of Treatment/DNR(Do Not Resuscitate) form

Additional Notes: