



**Enable
Fort Bend**

www.enablefortbend.com



Public Health
Prevent. Promote. Protect.

Mail To: Fort Bend County Health & Human Services
4520 Reading Road, Suite A, Rosenberg, TX 77471

2016

The following survey will assist Fort Bend County departments, such as the Office of Emergency Management and Health & Human Services, plan how to assist people with special needs in the county during an emergency or natural disaster.

This survey is not a request for hurricane evacuation transportation, since Fort Bend County is not an evacuation county. However, if severe weather is anticipated, or if there is severe wind damage or flooding after a storm, some people may need to be moved to a safer place.

During a disaster or an emergency, people with special needs may require assistance if they experience power outages, need medications or need medical support. This survey will help us identify people who may need assistance during an emergency and assist us in planning for such an event.

If you have a disability, use medical equipment at home, are hearing or vision impaired, or are elderly, and anticipate needing assistance please complete the following survey.

If you have any questions, please contact:

Fort Bend County Health & Human Services
4520 Reading Road, Suite A
Rosenberg, TX 77471
(281) 238-3514

Thank you for your assistance.



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Personal Information for Individual with need:

First Name: Last Name:

Physical Address:
Address:

City: State: TX Zip Code:

Primary Phone:

Secondary Phone: No Phone:

Email Address:

Mailing Address: (please enter if different from your physical address)

Address:

City: State: TX Zip Code:

Personal Information for Emergency Contact:

Relationship to person with need:

First Name: Last Name:

Address:

City: State: TX Zip Code:

Primary Phone:

Secondary Phone: No Phone:

Email Address:

Municipality: I live in the city limits of:

OR I live in unincorporated Fort Bend County:

Residence Type:

Single Family Unit Multi-family housing
 Mobile Home: Apartment Building

Date of Birth:

Height: **Weight:**

Gender: Male Female

Medical Care Information:

Primary Physician Name:

Phone Number:

Home Health / Hospice Name:

Phone Number:

Support Needs (mark all that apply):

- | | | |
|---|---|---|
| 1. <input type="checkbox"/> Sight Impaired | 11. <input type="checkbox"/> Tracheotomy | Has Wheelchair <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. <input type="checkbox"/> Hearing impaired | 12. <input type="checkbox"/> Feeding Tube | If yes, what type of wheelchair?: |
| 3. <input type="checkbox"/> Speech Impaired | 13. <input type="checkbox"/> Intravenous Line | 22. <input type="checkbox"/> Standard |
| 4. <input type="checkbox"/> Physically impaired | 14. <input type="checkbox"/> Foley catheter | 23. <input type="checkbox"/> Motorized |
| 5. <input type="checkbox"/> Completely bedridden | 15. <input type="checkbox"/> Allergies: _____ | 24. <input type="checkbox"/> Oversized |
| 6. <input type="checkbox"/> Mentally/memory impaired | Does not: | 25. <input type="checkbox"/> Reclinable |
| 7. <input type="checkbox"/> Dementia/Alzheimers | 16. <input type="checkbox"/> Have access to a motor vehicle | 26. <input type="checkbox"/> Scooter |
| 8. <input type="checkbox"/> On Dialysis | 17. <input type="checkbox"/> Have a radio or television | Require medical equipment that is not easily transportable: |
| 9. <input type="checkbox"/> Requires constant skilled nursing | 18. <input type="checkbox"/> Have a telephone | 27. <input type="checkbox"/> Oxygen Concentrator or Cylinder |
| 10. <input type="checkbox"/> Other reason for assistance | 19. <input type="checkbox"/> Speak English | 28. <input type="checkbox"/> Ventilator |
| | Has Difficulty walking and requires: | 29. <input type="checkbox"/> Suction Machine |
| | 20. <input type="checkbox"/> Walker/Cane | 30. <input type="checkbox"/> Other Equipment (please specify) |
| | 21. <input type="checkbox"/> Attendant to assist in walking | |

Required Assistance:

1. Does the person in need have medications that must be taken with them if relocated? Yes No
2. Does the person in need have a caregiver? Yes No
If yes, will the caregiver travel and/or stay with you? Yes No

Additional Information:



Pet Information (only for animals that would travel with you):

Pet # 1

Name:	
Type (dog, cat, etc.):	
Breed:	
Weight:	
Carrier/Cage Available?	<input type="radio"/> Yes <input type="radio"/> No
Leash Available?	<input type="radio"/> Yes <input type="radio"/> No
Muzzle Available?	<input type="radio"/> Yes <input type="radio"/> No

Pet #2

Name:	
Type (dog, cat, etc.):	
Breed:	
Weight:	
Carrier/Cage Available?	<input type="radio"/> Yes <input type="radio"/> No
Leash Available?	<input type="radio"/> Yes <input type="radio"/> No
Muzzle Available?	<input type="radio"/> Yes <input type="radio"/> No

Pet # 3

Name:	
Type (dog, cat, etc.):	
Breed:	
Weight:	
Carrier/Cage Available?	<input type="radio"/> Yes <input type="radio"/> No
Leash Available?	<input type="radio"/> Yes <input type="radio"/> No
Muzzle Available?	<input type="radio"/> Yes <input type="radio"/> No

Pet # 4

Name:	
Type (dog, cat, etc.):	
Breed:	
Weight:	
Carrier/Cage Available?	<input type="radio"/> Yes <input type="radio"/> No
Leash Available?	<input type="radio"/> Yes <input type="radio"/> No
Muzzle Available?	<input type="radio"/> Yes <input type="radio"/> No

Pet # 5

Name:	
Type (dog, cat, etc.):	
Breed:	
Weight:	
Carrier/Cage Available?	<input type="radio"/> Yes <input type="radio"/> No
Leash Available?	<input type="radio"/> Yes <input type="radio"/> No
Muzzle Available?	<input type="radio"/> Yes <input type="radio"/> No