MEDICAL FACT SHEET (*Contains Tracking System)

***Name:**

PAST MEDICAL PROBLEMS	NEW MEDICAL PROBLEMS
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.
6.	6.
7.	7.
8.	8.
9.	9.
10.	10.

ALLERGIES: _____

MEDICATIONS: _____

PAST HISTORY

A. Acute Hospitalizations

Diagnoses: _____

Month/Year: _____

B. Major Surgical Procedures before Admission to ALP

Procedure _____

Month/Year _____

DIET/DIETARY RESTRICTIONS: _____

TREATMENTS

_____

FUNCTIONAL STATUS

A. Ambulation Independent

☐ Independent, Assisted: Cane/Walker/Wheelchair
☐ Confined to Bed ☐ Confined to Chair

B. Continence

	Continent	Incontinent	Intermittent
Urine	☐	☐	☐
Stool	☐	☐	☐

☐ Indwelling Catheter – Indication: _____

TREATMENT STATUS **See Progress Sheet Dated** (mm/dd/yy)

☐ Durable Power of Attorney ☐ Full Code
☐ DNR ☐ Do Not Hosp. ☐ No Antibiotics
☐ No IVs ☐ No Feeding Tube ☐ Comfort Measures Only

C. Basic ADLs

	Independent	Assisted	Dependent
Bathing	☐	☐	☐
Dressing	☐	☐	☐
Grooming	☐	☐	☐
Feeding	☐	☐	☐
Transfers	☐	☐	☐

RESPONSIBLE PARTY

_____

Relationship:

Phone Number:

Who Contacted:

Date Contacted:

Time Contacted:

Initials of Individual Making Contact:

*Alternate Facility Sent to:

*Time Resident Sent to Alternate Facility:

Initials of Individual at Alternate Facility:

D. Instrumental ADLs

	Ind.	Assisted	Dep.
Cooking	☐	☐	☐
Housekeeping	☐	☐	☐
Managing Finances	☐	☐	☐
Managing Medications	☐	☐	☐
Shopping	☐	☐	☐
Get out into the Community	☐	☐	☐
Walking Outdoors	☐	☐	☐
Climbing Stairs	☐	☐	☐

LAST UPDATED	mm/yy	mm/yy	mm/yy	mm/yy	mm/yy
INITIALS:					

F I R E D R I L L F O R M

Completed Y	Completed N	Actions Taken
☐	☐	Use of the alarm system to announce the fire drill.
☐	☐	Notifying the Fire Department of the fire (simulated).
☐	☐	Notifying by intercom or word of mouth for the staff to begin evacuation.
☐	☐	Locate and isolate the fire.
☐	☐	Evacuation of the immediate area.
☐	☐	Evacuation of smoke compartment.
☐	☐	Evacuation completed when all participating staff and clients are at the predetermined meeting area.
☐	☐	Extinguishment of fire.
☐	☐	All clear is announced. Staff and client's can re-enter the building.
☐	☐	Were all windows shut?
☐	☐	Were all the doors shut?
☐	☐	Were vital documents secured?
☐	☐	Were medications secured?
☐	☐	Was this a total evacuation?
☐	☐	Were all smoke detectors tested and found functional?

Record of Emergency Evacuation Fire Drill

Date:	Name of the Facility:	
Time of Day/Shift:		Total Evacuation Time:
Type of Evacuation: ☐ Scheduled ☐ Unscheduled ☐ Training ☐ Actual Event		
Number of Clients Evacuated:	Number of Clients Not Evacuated:	Reason Clients Were Not Evacuated: _____

Names and Signatures of All Participating Staff

Print Name	Signature	Print Name	Signature

Person Completing Form: (Print)	Initial:	Date:

Retain Record for (2) Years

Retain Record for (2) Years

AFTER ACTION REPORT

Describe Problem Observed	Corrective Action to Be Taken	Assigned to Person/Unit	Date to be Completed	Completed	
				Yes	No
				☐	☐
				☐	☐
				☐	☐
				☐	☐
				☐	☐
				☐	☐
Person Completing Form: (Print)		Initial:	Date:		

S E M I N A N N U A L E M E R G E N C Y a n d D I S A S T E R D R I L L

Record of Emergency and Disaster Drill			
Date:	Name of the Facility:		
Time of the Day/Shift:		Total Evacuation/Moved Time:	
Type of Exercise: Evacuation:	Shelter-In-Place:	Actual Event:	
Was this conducted as a table-top-exercise? ☐ Yes ☐ No			
If you check "Yes" you must complete the "Reason Clients Were Not Evacuated/Moved" portion of this			
# of Clients Evacuated/Moved:		# of Clients Not Evacuated/Moved:	
Reason Clients Were Not Evacuated/Moved: _____			

Names and Signatures of All Participating Staff			
Print Name	**Signature**	**Print Name**	**Signature**
Person Completing Form: (Print)		Initial:	Date:

Attachments (Check if attached):
- ☐ Opportunities For Improvement (required if any):
- ☐ Copy of Exercise:
- ☐ Other(s) Describe: _____

Retain Record for Two (2) Years

O P P O R T U N I T Y F O R I M P R O V E M E N T

Describe Problem Observed	Corrective Action to be Taken	Assigned to Person/Unit	Date to be Completed	Completed	
				Yes	No
				☐	☐
				☐	☐
				☐	☐
				☐	☐
				☐	☐
				☐	☐
Person Completing Form: (Print)		Initial:		Date:	

Retain Record for Two (2) Years

Retain Record for Two (2) Years

A U T H O R I T Y T O E V A C U A T E

Key Position PRIMARY	Successor 1	Successor 2	Successor 3
Name: _____	Name: _____	Name: _____	Name: _____
Position Title: _____	Position Title: _____	Position Title: _____	Position Title: _____
Office #: _____	Office #: _____	Office #: _____	Office #: _____
Cell #: _____	Cell #: _____	Cell #: _____	Cell #: _____
Home #: _____	Home #: _____	Home #: _____	Home #: _____
Email: _____	Email: _____	Email: _____	Email: _____
Secondary Contact #: _____	Secondary Contact #: _____	Secondary Contact #: _____	Secondary Contact #: _____
Relationship/Name: _____	Relationship/Name: _____	Relationship/Name: _____	Relationship/Name: _____

Key Position PRIMARY	Successor 1	Successor 2	Successor 3
Notes: _____			

E V A C U A T I O N O N - S C E N E - C O M M A N D

On-Scene-Command	Successor 1	Successor 2	Successor 3
Name: _____	Name: _____	Name: _____	Name: _____
Position Title: _____	Position Title: _____	Position Title: _____	Position Title: _____
Office #: _____	Office #: _____	Office #: _____	Office #: _____
Cell #: _____	Cell #: _____	Cell #: _____	Cell #: _____
Home #: _____	Home #: _____	Home #: _____	Home #: _____
Email: _____	Email: _____	Email: _____	Email: _____
Secondary Contact #: _____	Secondary Contact #: _____	Secondary Contact #: _____	Secondary Contact #: _____
Relationship/Name: _____	Relationship/Name: _____	Relationship/Name: _____	Relationship/Name: _____

On-Scene-Command	Successor 1	Successor 2	Successor 3
Notes:			

EVACUATION PRIORITY CLIENTS

Clients Needing Assistance During Evacuations

Section I: **Client in need of additional assistance in the event of an evacuation.**

Client's Name:

Location in Facility (Bed/Room Number):

Staff Position Responsible for Making Sure Individual is Evacuated:

Ambulatory Status:

- ☐ Dependent
- ☐ Independent Assisted
  - ☐ Cane
  - ☐ Walker
  - ☐ Wheelchair
  - ☐ Other, please specify:
- ☐ Confined to Bed or Chair

Special Equipment Needed for Transfer/Transport:

- ☐ Oxygen
- ☐ Feeding Pump
- ☐ Suction Equipment
- ☐ IV, specify location:
- ☐ Hoyer Lift
- ☐ Multiple Assist, please specify number of individuals:
- ☐ Stretcher
- ☐ Specialty Bed, please specify:
- ☐ Wheelchair
- ☐ Impairments, please specify
- ☐ Other, please specify:

Transportation Needed:

- ☐ Van with Wheelchair Lift
- ☐ Automobile
- ☐ Ambulance

Identify Location(s) that Equipment Needed for Transfer Can be Found:

1.
2.
3.
4.
5.

Initials of Individual Updating Document/Date Document Updated:

( ), (mm/yy)	( ), (mm/yy)	( ), (mm/yy)	( ), (mm/yy)	( ), (mm/yy)
( ), (mm/yy)	( ), (mm/yy)	( ), (mm/yy)	( ), (mm/yy)	( ), ( )

CLIENT DAILY ROSTER

Client's Name	Room or Bed Number	Needs Evacuation Assistance
		☐
		☐
		☐
		☐
		☐
		☐
		☐
		☐
		☐
		☐
		☐
		☐
		☐
		☐
		☐
		☐
		☐
		☐
		☐
		☐
		☐
		☐
		☐
		☐
		☐
		☐
		☐
		☐
		☐
		☐
		☐
		☐
		☐
		☐
		☐

RELOCATION FACILITY INFORMATION

Relocation Facility	Facility Information
Name of Facility: _____	Primary Point of Contact/Emergency Contact
	Name:
	Position Title:
Address: _____	Telephone Number:
	Work Phone Number:
	Cell Phone Number:
Telephone Number:	Home Phone Number:
Day Phone Number:	Email:
Night Phone Number:	
Emergency Phone Number:	Secondary Point of Contact/Emergency Contact
	Name:
Affiliate: ☐ Yes ☐ No	Position Title:
MOU Contract: ☐ Yes ☐ No	Telephone Number:
If yes, attach a current signed copy. If No, provide a detailed explanation in the "Notes" section of the steps taken to secure a contract or MOU from this facility.	Work Phone Number:
	Cell Phone Number:
	Home Phone Number:
	Email:
Notes	
_____	
Written Directions: (Attach Maps)	
Primary: _____	
Secondary: _____	

M O V I N G E S S E N T I A L R E S O U R C E S

Moving Essential Resources
Describe: _____

Moving Essential Resources
Notes: _____

C O N T R A C T U A L & V E N D O R S E R V I C E S

Vendor	Services and or Resources Provided	Representative's Name	Work #	Cell #	Home or Emergency #	Email

C O M M U N I C A T I O N S Y S T E M S

SYSTEM	EQUIPMENT	Representative's Name	Work #	Cell #	Emergency #

CLIENT'S FAMILY or LEGAL REPRESENTATIVE CONTACTS

Client's Name	Primary Family Contact or Legal Representative	Work #	Home #	Cell #	Email or Texting	Secondary Contact

TRANSPORTATION CONTRACTOR INFORMATION

Transportation Contractor	Business Information
Name of Business: _____	Primary Point of Contact/Emergency Contact
	Name:
	Position Title:
Address: _____	Telephone Number:
	Work Phone Number:
	Cell Phone Number:
Telephone Number:	Home Phone Number:
Day Phone Number:	Email:
Night Phone Number:	
Emergency Phone Number:	Secondary Point of Contact/Emergency Contact
	Name:
Affiliate: ☐ Yes ☐ No	Position Title:
MOU Contract: ☐ Yes ☐ No	Telephone Number:
If yes, attach a current signed copy. If No, provide a detailed explanation in the "Notes" section of the steps taken to secure a contract or MOU from this facility.	Work Phone Number:
	Cell Phone Number:
	Home Phone Number:
	Email:
Number of Passenger Seats:	
Special Needs Equipped: ☐ Yes ☐ No Describe: _____	
Notes	

I N - H O U S E T R A N S P O R T A T I O N

In-House Transportation
Year:
Make:
Model:
Keys Located:
Tag Number:
Serial Number:
Number of Passenger Seats:
Special Needs Equipped: Yes ☐ No ☐ Describe: _____
Special Class License to Operate: Yes ☐ No ☐
Potential Staff Drivers
Name: Work Phone Number: Home Phone Number: Cell Phone Number:
Name: Work Phone Number: Home Phone Number: Cell Phone Number:
Insurance Information
Company Name:
Agents Name:
Insurance Policy Number:
Telephone Number:
Day Phone Number:
Night Phone Number:
Emergency Phone Number:

S T A F F I N G						
Name	**Position / Title**	**Work #**	**Home #**	**Cell #**	**Email or Texting**	**Direct Connect #**

S T A F F I N G						
Name	**Position / Title**	**Work #**	**Home #**	**Cell #**	**Email or Texting**	**Direct Connect #**