Public Health
Prevent. Promote. Protect.

Department of: HEALTH

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http://www.co.burlington.nj.us/health

Board of Chosen Freeholders
County of Burlington
New Jersey

Physical Address:
15 Pioneer Boulevard
Westampton, NJ 08060

Mailing Address:
49 Rancocas Road
P.O. Box 6000
Mount Holly, NJ 08060-6000

Medical Needs Shelter Client Record

To be completed or verified by staff receiving clients at MNS

Insert Picture Here

Admit Date: __/__/__ Discharge Date: __/__/__
Bed #: _____

Arrival- Date: _____ Time: _____ Mode of Arrival: _____ Shelter Location: _____

Name- Last: _____ First: _____ Middle: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____ Cell Phone #: _____

Residence Type: _____ Living Situation: ☐Alone ☐Relative ☐Other:_____

DOB: _____ Age (Years): _____ Sex: _____

Weight (lbs.): _____Height: ____(ft.) ____(in.) Primary Language: _____

Name of Emergency Contacts:

Local: _____ Relationship:_____ Phone: _____

Non-Local: _____ Relationship: _____ Phone: _____

Medicare/Medicaid Number: _____ **Insurance Carrier/Number**: _____

To Be Completed By Health and Medical Staff

Number of caregivers/family members accompanying client to MNS: _____

Caregiver/family member names: _____

Qualifying Medical Need: _____

Allergies:_____

Medical Needs of Client:

Medically Depended on Electricity: ☐O2 Concentrator ☐Feeding Pump ☐Suction ☐Other: _____	Oxygen Dependent: ☐24 hour ☐Only Overnight ☐Nebulizer ☐CPAP O2 Type: _____ Liters Flow: _____L/min O2 Company: _____ Phone: _____	
☐Assistance with medications ☐Insulin Dependent ☐Assistance with insulin ☐Diet	☐Mental Health Problems ☐Anxiety/Depression ☐Alzheimer's/Dementia- full-time caregiver must be present at all times during client stay at shelter	☐Vision Loss/Impaired ☐Hearing Loss/Impaired ☐Speech Impaired ☐Cognitive Impaired
☐Incontinence ☐Dialysis Dependent	☐Mobility Impaired ☐Walker ☐Cane ☐Wheelchair	☐Open Wounds ☐Decubitus
☐Other/Comments: _____ _____ _____ _____	☐Trained Service Animal Name of Animal:_____ ☐Refer to CART Type of Animal: _____ What work or task has the animal been trained to perform? _____	

Comments/Notes: _____
_____

Medical Information (Check box if you receive the information)

Primary Doctor: _____ Phone: _____
Home Health Agency: _____ Phone: _____
Long Term Care Facility: _____ Phone: _____
Dialysis: _____ Phone: _____
Pharmacy: _____ Phone: _____
□Patient Assigned to Hospice Hospice Name: _____ Phone: _____
□Do Not Resuscitate (DNR) □POLST □Healthcare Proxy/POA □Living Will
□Client Identification Verified- Identification must be on the client at all times during the shelter event.
List Medications: _____
_____
□Self-administer Medications □Caregiver administration □Shelter Nurse Administration
□Offer Medication Storage by Shelter Nurse (Controlled Substance) □Agree □Refuse
Medical Conditions: _____
Medical Equipment/Supplies Brought to Shelter: _____
□Dentures □Wheel chair □Walker/Cane/Crutches □Hearing Aid □Glasses/Contact Lens
□CPAP/BiPAP □Glucometer □Nebulizer
Other: _____
Have you been HOSPITALIZED within the last three months? □Yes □No Why:_____
_____
Comments/Notes/Referral: _____
Health or Medical Staff Name Completing the Form: _____

Signature: ____ Date: __________

MNS Medical Update			
Date/Time	**Observations/Notes Problem**	**Plan/Tx/Med/Action**	**Signature**

HCP Name	Signature	HCP Name	Signature	HCP Name	Signature
HCP Name	Signature	HCP Name	Signature	HCP Name	Signature
HCP Name	Signature	HCP Name	Signature	HCP Name	Signature