



Public Health
Prevent. Promote. Protect.

Department of: HEALTH

Phone: (609) 265-5548
Fax: (609) 265-3152
E-Mail: bchd@co.burlington.nj.us
http://www.co.burlington.nj.us/health

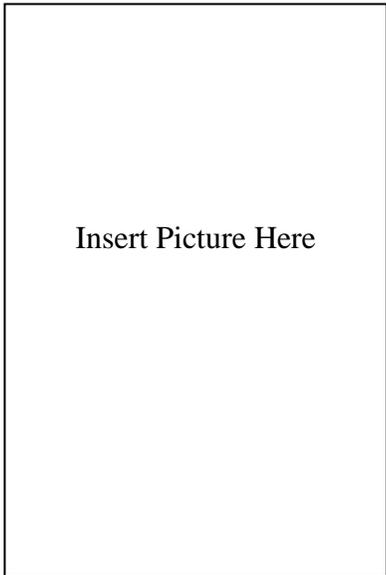
Board of Chosen Freeholders County of Burlington New Jersey



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



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: <input type="checkbox"/> O2 Concentrator <input type="checkbox"/> Feeding Pump <input type="checkbox"/> Suction <input type="checkbox"/> Other: _____	Oxygen Dependent: <input type="checkbox"/> 24 hour <input type="checkbox"/> Only Overnight <input type="checkbox"/> Nebulizer <input type="checkbox"/> CPAP O2 Type: _____ Liters Flow: _____ L/min O2 Company: _____ Phone: _____
--	--

<input type="checkbox"/> Assistance with medications <input type="checkbox"/> Insulin Dependent <input type="checkbox"/> Assistance with insulin <input type="checkbox"/> Diet	<input type="checkbox"/> Mental Health Problems <input type="checkbox"/> Anxiety/Depression <input type="checkbox"/> Alzheimer's/Dementia- full-time caregiver must be present at all times during client stay at shelter	<input type="checkbox"/> Vision Loss/Impaired <input type="checkbox"/> Hearing Loss/Impaired <input type="checkbox"/> Speech Impaired <input type="checkbox"/> Cognitive Impaired
---	---	--

<input type="checkbox"/> Incontinence <input type="checkbox"/> Dialysis Dependent	<input type="checkbox"/> Mobility Impaired <input type="checkbox"/> Walker <input type="checkbox"/> Cane <input type="checkbox"/> Wheelchair	<input type="checkbox"/> Open Wounds <input type="checkbox"/> Decubitus
--	---	--

<input type="checkbox"/> Other/Comments: _____ _____ _____	<input type="checkbox"/> Trained Service Animal Name of Animal: _____ <input type="checkbox"/> 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: _____

