



Public Health
Prevent. Promote. Protect.

Department of: HEALTH

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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 (MNS) Inventory of Personal Effects

Patient Name: _____ Bed No. _____

Description:

| Clothing: | |
|------------------|----------|
| Coat | Shoes |
| Shirt | Hat |
| Sweater | Belt |
| Bras | Slippers |
| Underwear | Bathrobe |
| Pants/Shorts | Pajamas |
| Socks | Dresses |

| Durable Medical Equipment, Prosthetics, and Valuables | |
|--|--|
| Cane | Glasses |
| Crutches | Purse |
| Wheelchair | Wallet |
| Walker | Electric razor/toothbrush |
| Motorized transport (describe): | Dentures: Full Upper () Full Lower () Partial Upper () Partial Lower () |
| Prosthetics (Describe): | Jewelry (Describe): |
| Cell Phone (Describe): Charger: | Other: |

| Medications Kept With Patient | |
|--------------------------------------|--|
| | |
| | |
| | |
| | |

- I certify that the above is a correct list of my personal belongings. I take full responsibility for retaining in my possession the articles listed above and any others brought to me while a resident in this MNS.
- All items brought for the personal use of the patient must be properly marked and listed above.
- I understand the MNS will not be responsible for any valuables, money, or clothing left in the possession of the patient.

Signature of Patient (or Relative): _____ Date: _____

Signature of MNS Staff: _____ Date: _____

Disposition on Discharge/Transfer:

- Upon Discharge/Transfer, all personal items are sent with patient or picked up by responsible party.

Signature of Patient (or Relative): _____ Date: _____

Signature of MNS Staff: _____ Date: _____