

"Operation Evacuation Questionnaire"

Disability Resource Center

Consumer ID: _____
First Name: _____
Middle Initial: _____
Last Name: _____
Sex: _____
Ethnicity: _____
Address: _____
City: _____
County: _____
State: _____
Postal Code: _____
Birthdate: _____
Home Phone: _____
Mobile Phone: _____
Work Phone: _____
Fax Number: _____
Email: _____
Disability Primary: _____
Referred By: _____
Caregiver Name: _____
Caregiver Phone: _____
Intake Date: _____
Notes: _____

1) Do you or someone you care for regularly have a significant disability that may result in any of the following?

“Please reply with a yes or no response to the questions below.
You can write your response at the end of the question”

1a. Limitations that may interfere with walking or using stairs

1b. Reduced stamina, fatigue or tire easily

1c. Seizures, respiratory or heart conditions that may be triggered by stress

1d. Emotional, cognitive, or thinking difficulties that may require assistance in an emergency

1e. Vision or hearing loss that may inhibit you in an emergency situation

1f. Do you rely on assistive devices or medically necessary items that may not work in emergency

2) In an emergency (hurricane, flooding) would you need shelter provided?

3) Would you need transportation to get to a shelter?

4) Describe the type or level of assistance you would need once at the shelter (oxygen, diabetic monitoring, bowel/bladder care, transfers assistance, companion/guide animal) _____

5) Do you have someone who can assist you or care for your needs during evacuation or recovery?

6) Do you need assistance with the development of your emergency evacuation plan?

Additional comments/problems: _____

Questions or comments please call (843) 225-5080

Please mail your completed questionnaire to the following address.

**Disability Resource Center
7944 Dorchester Rd.
Suite 5
N. Charleston, SC 2948**