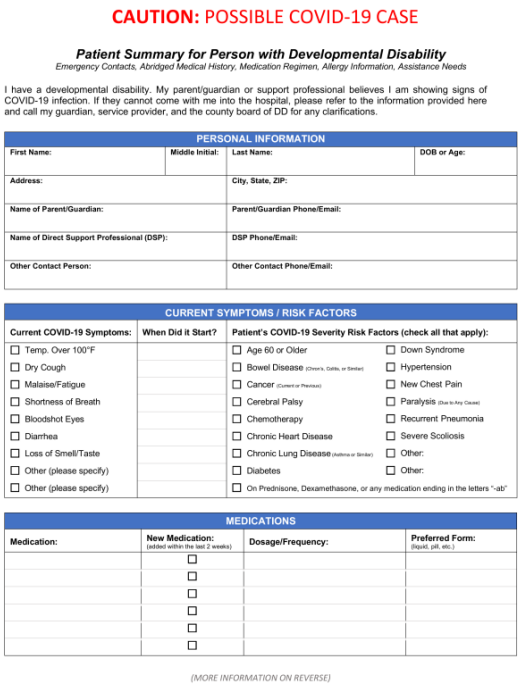
The Arc of New Jersey

Dear Colleague,

We know that all families and DSPs are doing everything they can to prevent individuals with intellectual and developmental disabilities (I/DD) from being diagnosed with COVID-19. However, despite everyone's best efforts, a small number of individuals have already received this dreaded diagnosis, and some will likely be hospitalized. In an effort to prevent further spread of the Coronavirus, most hospitals are not allowing visitors because the virus is so contagious. Because it is likely that visitors will not be permitted, this two-page form may be helpful for anyone with I/DD who might need to be hospitalized during the COVID-19 pandemic. Click **here** or the image below to view this form.



CAUTION: POSSIBLE COVID-19 CASE

Patient Summary for Person with Developmental Disability

Emergency Contacts, Abridged Medical History, Medication Regimen, Allergy Information, Assistance Needs

I have a developmental disability. My parent/guardian or support professional believes I am showing signs of COVID-19 infection. If they cannot come with me into the hospital, please refer to the information provided here and call my guardian, service provider, and the county board of DD for any clarifications.

PERSONAL INFORMATION			
First Name:	Middle Initial:	Last Name:	DOB or Age:
Address:		City, State, ZIP:	
Name of Parent/Guardian:		Parent/Guardian Phone/Email:	
Name of Direct Support Professional (DSP):		DSP Phone/Email:	
Other Contact Person:		Other Contact Phone/Email:	

CURRENT SYMPTOMS / RISK FACTORS			
Current COVID-19 Symptoms:	When Did it Start?	Patient's COVID-19 Severity Risk Factors (check all that apply):	
☐ Temp. Over 100°F		☐ Age 60 or Older	☐ Down Syndrome
☐ Dry Cough		☐ Bowel Disease (Crohn's, Colitis, or Similar)	☐ Hypertension
☐ Malaise/Fatigue		☐ Cancer (Current or Previous)	☐ New Chest Pain
☐ Shortness of Breath		☐ Cerebral Palsy	☐ Paralysis (Due to Any Cause)
☐ Bloodshot Eyes		☐ Chemotherapy	☐ Recurrent Pneumonia
☐ Diarrhea		☐ Chronic Heart Disease	☐ Severe Scoliosis
☐ Loss of Smell/Taste		☐ Chronic Lung Disease (Asthma or Similar)	☐ Other:
☐ Other (please specify)		☐ Diabetes	☐ Other:
☐ Other (please specify)		☐ On Prednisone, Dexamethasone, or any medication ending in the letters "-ab"	

MEDICATIONS			
Medication:	New Medication: (added within the last 2 weeks)	Dosage/Frequency:	Preferred Form: (liquid, pill, etc.)
	☐		
	☐		
	☐		
	☐		
	☐		
	☐		

(MORE INFORMATION ON REVERSE)

The health passport form provides a concise way to record all of the essential aspects of the individual's medical history including COVID-19 symptoms and risk factors; personal assistance needs; and the individual's self-expression, likes and dislikes. It is a fillable form, and the information can be entered online, or the form can be printed and filled in by hand. The health passport can be duplicated, with a request from the caregivers that it should be readily available to every health care professional who is caring for the individual at the hospital.

This form was created by the Ohio Association of County Board of Developmental Disabilities with substantial input and guidance from Dr. Susan Abend of the Right Care Now Project. The Arc of New Jersey made a small change on the original form to better reflect the I/DD service system in New Jersey.

This is one of many emails that The Arc of New Jersey is distributing in an effort to help individuals with I/DD, their families, and staff to be safe and healthy throughout the COVID-19 pandemic. To see other emails that The Arc of New Jersey has distributed on this topic, please go to https://www.arcnj.org/information/covid-19-updates-information.html

Thank you.
Bev

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