Resident Survey of Special Medical Needs

Property Management Instructions:	Provide this voluntary form to facility residents upon signing of a lease and make the form readily available to them to submit, change, or update their information at any time.
Resident Instructions:	Completing this form is voluntary. If you choose to complete the form, please provide any updates to your property manager as needed. The information you choose to provide will be submitted to the City of New Orleans and will be used to better understand the special medical needs of residents during an emergency or disaster.

Tenant 1 - Basic Information	
First Name:	
Last Name:	
Phone Number:	
Age (in years):	

Tenant 1: Communication Needs					
Preferred Language (circle one)	English	Spanish	Vietnamese	American Sign Language	Other
If other, please write description here:					
Does this individual identify as blind, low vision, deaf or hard of hearing?	Blind	Low Vision	Deaf	Hard of Hearing	Deaf-Blind

Tenant 1: Mobility Assistance					
Does this individual use any form of durable medical equipment to support their independence? (circle all that apply)	Cane	Walker	Wheelchair	Powerchair or Scooter	Other
Is this individual able to leave the building without caregiver support? (circle one)	Yes	No	Decline to answer		
Is this individual able to leave the building without public safety support? (circle one)	Yes	No	Decline to answer		

Tenant 1: Electricity Dependence				
Does this individual depend on an elevator to leave the building? (circle one)	Yes	No	Decline to answer	
Does this individual have medical equipment or refrigerated medication requiring access to stable power? (circle one)	Yes	No	Decline to answer	
Does this individual require oxygen? (circle one)	Yes	No	Decline to answer	

Tenant 1: Other Medical Information	
Please include any other information related to medical needs that would be important for emergency responders to know	

Tenant 2 - Basic Information					
First Name:					
Last Name:					
Phone Number:					
Age (in years):					
Tenant 2: Communication Needs					
Preferred Language (circle one)	English	Spanish	Vietnamese	American Sign Language	Other
If other, please write description here:					
Does this individual identify as blind, low vision, deaf or hard of hearing?	Blind	Low Vision	Deaf	Hard of Hearing	Deaf-Blind
Tenant 2: Mobility Assistance					
Does this individual use any form of durable medical equipment to support their independence? (circle all that apply)	Cane	Walker	Wheelchair	Powerchair/Scooter	Other
Is this individual able to leave the building without caregiver support? (circle one)	Yes	No	Decline to answer		
Is this individual able to leave the building without public safety support? (circle one)	Yes	No	Decline to answer		
Tenant 2: Electricity Dependence					
Does this individual depend on an elevator to leave the building? (circle one)	Yes	No	Decline to answer		
Does this individual have medical equipment or refrigerated medication requiring access to stable power? (circle one)	Yes	No	Decline to answer		
Does this individual require oxygen? (circle one)	Yes	No	Decline to answer		
Tenant 2: Other Medical Information					
Please include any other information related to medical needs that would be important for emergency responders to know					

NOTE: If more than two tenants live in this unit, please complete an additional form to provide the information above for those tenants.