



## Special Needs Registry & Heads Up Program

Please fill out this form completely and to the best of your knowledge and return to the following address:

Williamsburg Human Services Phone: (757) 220-6161  
401 Lafayette Street E-mail: [social@williamsburgva.gov](mailto:social@williamsburgva.gov)  
Williamsburg, VA 23185

Required fields are indicated with an \*.

### GENERAL INFORMATION

\*First name: \_\_\_\_\_

Middle name: \_\_\_\_\_

\*Last name: \_\_\_\_\_

\*Date of birth: \_\_\_\_\_

\*Sex: \_\_\_\_\_

\*Street Address: \_\_\_\_\_

\*City/State/Zip: \_\_\_\_\_

How many occupants at this address: \_\_\_\_\_

Email address: \_\_\_\_\_

How did you hear about the registry/program? \_\_\_\_\_

\*Primary phone number: \_\_\_\_\_

Phone type  TTY  SMS  Relay Voice

\*Secondary phone number: \_\_\_\_\_

Phone type  TTY  SMS  Relay Voice

Preferred contact method: (circle one) Regular Mail / Email / Primary Phone

Preferred contact time: \_\_\_\_\_

What is your residence type:  House  Apartment  Other \_\_\_\_\_

Is there an elevator for use at residence:  Yes  No

**PERSONAL INFORMATION**

Do you have a service animal:  Yes  No Animal weight \_\_\_\_\_ lbs

Do you have other pets:  Yes  No

Do you have a care giver or attendant:  Yes  No

Who is your home health agency: \_\_\_\_\_

Do you plan to go to shelter if told to evacuate:  Yes  No

Do you have a generator:  Yes  No

Do you have an emergency plan:  Yes  No

Physical Considerations:  Bladder  Cognitive Disorder  
 Mental Condition  Seizures  
 Bowel  Cardiac Condition  
 Pulmonary Condition  Weigh over 300 pounds

Do you have other physical considerations: \_\_\_\_\_

Do you use any of the following:  Apnea Monitor  Special Diet  
 Nebulizer  Wound Dressing  
 Catheter  Tracheotomy  
 Oxygen  IV Therapy  
 CPAP  Ventilator  
 Electricity-intermittent  Colostomy  
 Electric-continuous  Dialysis  
 G or J tube  Pacemaker or Related  
 Hospice care  Prescription meds  
 Insulin (non-refrig)  Suctioning  
 Insulin (refrig)

Do you use other medical or therapeutic items: \_\_\_\_\_

Allergies: \_\_\_\_\_

Mobility:  Ambulatory  Power chair or scooter  
 Ambulatory with help  Walker/cane/crutches  
 Manual wheelchair  White cane

Do you have other mobility considerations: \_\_\_\_\_

Do you require assistance with:  Bathing  Feeding  
 Getting dressed  Guidance (visual or other)  
 Communication  Use of Toilet

Is this condition permanent:  Yes  No

**TRANSPORTATION INFORMATION**

Do you have access to private transportation:  Yes  No  
Can you ride a regular bus with no lift:  Yes  No  
Do you require an ambulance for transportation:  Yes  No

Do you use any of the following:  HRT Bus/trolley  WAT  
 Logisticare  Taxi  
 Handi-ride

Do you have other restrictions/comments: \_\_\_\_\_

**EMERGENCY CONTACT**

Primary physician: \_\_\_\_\_

Physician phone: \_\_\_\_\_

\*Primary emergency contact: Name: \_\_\_\_\_

\*Phone: \_\_\_\_\_

Phone type:  TTY  SMS  Relay Voice

Alternative phone: \_\_\_\_\_

Phone type:  TTY  SMS  Relay Voice

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Second emergency contact: Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Phone type:  TTY  SMS  Relay Voice

Alternative phone: \_\_\_\_\_

Phone type:  TTY  SMS  Relay Voice

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

**SUMMARY**

Summary of needs or concerns: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Person filling out form: \_\_\_\_\_

Relationship of person filling out form: \_\_\_\_\_

Date form completed: \_\_\_\_\_

Information submitted on this form will be used by the Heads Up program and the Medical Needs Registry. The Heads Up program is designed to assist emergency responders in rendering emergency services to Williamsburg residents. The Medical Needs Registry is an emergency preparedness tool that will be used by local emergency managers to communicate with people who have medical needs for emergency preparedness planning purposes. Information is entered into a secure database and will be kept confidential. It is the responsibility of the citizen to report any changes to ensure accurate information. Please contact the Williamsburg Human Services at 757-220-6161 with any further questions or concerns.



**FOR OFFICE USE ONLY**

Person collecting information: \_\_\_\_\_

Date entered: \_\_\_\_\_ Entered by: \_\_\_\_\_

Date updated: \_\_\_\_\_ Updated by: \_\_\_\_\_

Date purged: \_\_\_\_\_ Reason : \_\_\_\_\_