BOROUGH OF FANWOOD
SENIOR CITIZENS/RESIDENTS WITH SPECIAL NEEDS
REGISTRY SURVEY

Complete the following information and return this form to the Senior Citizen Coordinator, Borough Hall, 75 North Martine Avenue, Fanwood, NJ 07023. If you need assistance in completing the form or you want someone to pick up the form from you, please call Borough Hall, 908 322 8236. Please send any changes in as soon as possible and complete a new Survey no later than every six months or as Physical/Medical conditions change.

All information will be kept strictly confidential!

PERSONAL INFORMATION: **Date Prepared:** _____

Name: _____ _____ _____ **Spouse:** _____
Last **First** **MI**

Home Address: _____ **Apt. No:** _____

Mailing Address: _____

City: _____ **Zip Code:** _____ **Phone:** _____

Other (describe): _____ **Email:** _____

Age: _____ **Date of Birth:** _____ ☐ **Male** ☐ **Female**

Residence Type: ☐ **Private Residence** ☐ **Apt/Condo** ☐ **Assisted Living** ☐ **Group Home**
☐ **Retirement/Sr. Housing**

Name of Complex/Subdivision: _____

Live Alone: ☐ **Yes** ☐ **No** **Live With:** _____

Pets: ☐ **Yes** ☐ **No** **Service Animal:** ☐ **Yes** ☐ **No**

Yearly Resident: ☐ **Yes** ☐ **No** **If no, from:** _____ **to:** _____

Understands English: ☐ **Well** ☐ **Not Well** ☐ **Not At All**

Primary Language Spoken: _____

SOCIAL ACTIVITY/INTERESTS:

Senior Club Member: ☐ **Yes** ☐ **No** **Comments:** _____

Exercise Classes: ☐ **Yes** ☐ **No** **Comments:** _____

Education Classes: ☐ **Yes** ☐ **No** **Comments:** _____

Volunteer Work: ☐ **Yes** ☐ **No** **Comments:** _____

Book Club: ☐ **Yes** ☐ **No** **Comments:** _____

Trips: ☐ **Yes** ☐ **No** **Where:** _____

Transportation for shopping and physician visits: ☐ **Yes** ☐ **No** **Comments:** _____

Assistance with household chores: ☐ **Yes** ☐ **No** **Comments:** _____

MEDICAL/PHYSICAL NEEDS: Information utilized by OEM, Police, Fire & Rescue Squad

Medical Disability: _____

_____

_____

Hospice Patient: ☐ **Yes** ☐ **No** **(Include copy of physician's "Do Not Resuscitate" Order)**

Medications (List all with dose and if refrigeration is required):

_____ _____ _____

_____ _____ _____

_____ _____ _____

Medication Allergies (List): _____

Physician: _____

Address: _____

Phone Number: _____

EVACUATION INFORMATION:

Do you care for self: ☐ **Yes** ☐ **No** **Caretaker:** ☐ **Yes** ☐ **No**

Name of Caretaker: _____ **Phone:** _____

(CHECK ALL THAT APPLY)

Mobility Status:	**Wheelchair:**	**Hearing:**	**Mental Status:**	**Life Support System:**
☐ self	☐ self propelled	☐ hearing aid	☐ no special needs	☐ no ☐ yes
☐ cane	☐ motorized	☐ deaf	☐ Alzheimers	☐ respirator
☐ walker	**Transportation Needs:**	**Sight:**	☐ Dementia	☐ generator in home
☐ crutches	☐ accessible van	☐ glasses needed	☐ developmental disability	
☐ scooter	☐ accessible bus	☐ blind	☐ cognitive impairment	
☐ bed bound	☐ ambulance	☐ seeing eye dog	☐ mental health condition	

OXYGEN USE: ☐ **Yes** ☐ **No** **Number of hours each day:** _____

☐ **portable tanks** **Supplier:** _____

☐ **concentrator**

☐ **respirator** **Type:** _____

EMERGENCY CONTACTS:

Name: _____ **Relation:** _____

Address: _____ **Email/Fax:** _____

Phone/Cell: _____ **Other Info:** _____

Out of State Contact: _____ **Relation:** _____

Phone/Cell: _____

_____ _____

Print Name **Signature**