Rhode Island Special Needs Emergency Registry

For Rhode Islanders with disabilities, chronic conditions, and special healthcare needs

The Rhode Island Department of Health (HEALTH) and the Rhode Island Emergency Management Agency (RIEMA) maintain a registry for **Rhode Island residents with disabilities, chronic conditions, and special healthcare needs**. By participating in the Registry, you permit RIEMA and HEALTH to share your information with local and state emergency responders, such as your town/city police or fire department. The information that you provide may help responders meet your needs during an emergency.

Instructions: To be included in the Registry, please fill out this form, sign it, and send it to **RIEMA, Database Manager 645 New London Avenue, Cranston, RI 02920 OR register online at www.health.ri.gov/emregistry.** If you have questions, please call (401) 946-9996 (voice) or RI Relay 711 (TTY). If you cannot fill out this form on your own, please have a family member, caregiver, or other representative complete the form and submit it on your behalf.

☐ New Registration ☐ Updated Registration

General Information *(Fields marked with an asterisk (*) are mandatory)* 10/2013

NAME: First:_____ Middle: _____ Last: _____SEX: ☐ M ☐ F

DATE OF BIRTH:_____ STREET ADDRESS*:_____

APARTMENT/UNIT or FLOOR:_____ CITY/TOWN*: _____ ZIP CODE*: _____

PHONE:_____ CELL PHONE:_____ (**A phone number is required)*

TTY:_____ E-MAIL:_____

EMERGENCY CONTACT NAME:_____ CONTACT'S PHONE:_____

Life Support Systems

Which of the following do you use? (Check all that apply)

☐ Oxygen: ☐ Tanks ☐ Concentrator

☐ Respirator/Ventilator: ☐ Battery backup for unit?

☐ Dialysis: ☐ Clinic ☐ Home

☐ Electrical: ☐ Pacemaker ☐ Defibrillator

Are you diabetic? ☐ Yes ☐ No

Insulin-dependent? ☐ Yes ☐ No

☐ Other:_____ ☐ None of the Above

Sensory, Cognitive, and Psychiatric Conditions

Which of these apply to you? (Check all that apply)

☐ Visually impaired ☐ Speech impaired

☐ Legally blind ☐ Non-verbal

☐ Hard of hearing ☐ Cognitively/Developmentally delayed

☐ Use hearing aids

☐ Deaf ☐ Autism Spectrum Disorder

☐ Seizure disorder ☐ Alzheimer's/Dementia

☐ Other:_____ ☐ Psychiatric Condition:_____

☐ None of the above _____

Mobility

Are you confined to bed? ☐ Yes ☐ No

Can you walk without assistance? ☐ Yes ☐ No

Which of the following do you use? (Check all that apply)

☐ Wheelchair/Mobility Vehicle

☐ Walker/Cane ☐ Prosthesis:_____

☐ Crutches ☐ Other:_____

☐ Assistive animal ☐ None of the above

Other Disabilities (*Use the back of this form, if needed)*

Please list other disabilities or relevant conditions:

☐ _____

_____

_____

Language

In what language do you prefer to receive emergency communications or assistance?

☐ English ☐ Spanish ☐ French ☐ Portuguese

☐ Mandarin ☐ Cantonese ☐ Russian ☐ Krahn

☐ Khmer ☐ Farsi ☐ Lao

☐ Cape Verdean Creole ☐ Other: _____

ETHNICITY: Hispanic or Latino? ☐ Yes ☐ No **RACE**: ☐ White ☐ African American/Black ☐ Asian

☐ Native Hawaiian/Other Pacific Islander ☐ American Indian/Alaska Native ☐ Other: _____

NOTE: By signing this form and submitting it to RIEMA/HEALTH, I agree to permit my information to be shared with local and state emergency responders. I understand that this is a voluntary program. While RIEMA/HEALTH will share this information in order to better assist me during an emergency, they cannot guarantee assistance in all cases.

Signature: _____ Print Name: _____

Date: _____ List relationship if completing on individual's behalf: _____