

Name:_____

Date of Birth: _____ Allergies: _____

Diagnosis: _____

Healthcare Provider	Specialty	Address	Phone	Fax
	Family			
	Dentist			
	PHARMACY			

Agency Responsible for Providing Care? No Yes _____ Tel _____

		(Name of agency/contact person)	
Consent Status:	Can give own consent	Unable to give consent and no guardiar	1
	Consent from guardian	Name Tel #	¢
Health Care Rep:	□ No □ Yes Name	Tel #	
Resuscitation Status:	DNR 🛛 Full Resuscita	ation	

Medications:

□ Medication sheet/record attached OR □ List attached

□ Communication Difficulties/Uses □ Needs Assistance □ Needs Assistance □ Ambulation Aids _WalkerCaneCrutches □ Verbalization □ Totally Dependent □ Ambulation Aids _WalkerCaneCrutches □ Not Able to Communication device/method: □ Other □ Non-Ambulatory □ Not Able to Communication device/method: □ Other □ Non-Ambulatory □ Not Able to Communication device/method: □ Other □ Independent □ Independent/Self Medicates □ Independent □ Needs Assistance: □ Independent □ Needs Assistance: □ Needs Assistance: □ Needs Assistance: □ Independent □ Needs Assistance: □ Independent □ Needs Assistance: □ Needs Assistance: </th <th>Communication</th> <th>Dining/Eating</th> <th>Ambulation</th>	Communication	Dining/Eating	Ambulation
Image: Second communication difficulties/Uses Gestures Image: Totally Dependent Image: Ambulation AidsWalkerCaneCrutches Special communication device/method: Other	Able to Communicate	Independent	IndependentSteadyUnsteady
Communication difficulties/Uses Gestures Fed Through a Tube Wheelchair Special communication device/method: Other Non-Ambulatory Independent Independent Independent Needs Assistance: Medication Administration: Personal Hygiene Independent Medication Administration: Independent Continent Medication Administered by Staff Needs Assistance: Continent Orthotics Type: Incontinent Bould Other Toileting Ability Catheterized Pain Response Regular Regular Other: Other Ground Chopped Vision Usual Response to Medical Exams Ground Pureed Normal Cooperates Partially Cooperates Resistant Fearful Blind Sedation for clinical visits (explain): Sedation for examination (explain): Sedation for examination (explain): Other: Special positioning required for assistance with exams (explain): Double staffing required for assistance with exams (explain): Dother: Special positioning required for examination (explain): Prefers end of day appointments Other:	Communication Difficulties/Uses	Needs Assistance	Needs Assistance1 person2 people
Special communication device/method: Other Nor-Ambulatory Nort Able to Communicate Needs Medication Administration: Independent Independent Independent/Sef Medicates Independent Bedentlows / Dentures Pill Organizer Set up Weekly Needs Assistance: Independent Continent Bowel Bladder Other Tolicting Ability Normal Incontinent Bowel Bladder Other Thicken Liquid Regular Other: Other Thicken Liquid Regular Ground Normal Indique (explain): Ground Pureed Pureed Vision Usual Response to Medical Exams Other: Sectation for clinical visits (explain): Pureed Wears Glasses/Contacts Sectation for clinical visits (explain): Sectation for clinical visits (explain): Double staffing required for assistance with exams (explain): Double staffing required for assistance with exams (explain): Prefers end of day appointments Other: Other: Prefers early day appointments Prefers end of day appointments Prefers end of day appointments	Verbalization	Totally Dependent	Ambulation AidsWalkerCaneCrutches
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	Diabetes Yes No Incontin	ence Yes No	
Insomnia Yes No Skin Integrity/ Immobility Yes No Other		egrity/ Immobility Yes No	Other:

Tuberculosis Skin Test (PPD): Have you ever had a positive skin test for tuberc	ulosis? 🗆 Yes	;	🗆 No	Unsure
If yes, was any treatment given?		es (describe) lo (explain)		
Date of last PPD:				
Childhood Illness: Measles Mumps	🗆 Rubella	Chickenpox	Rheumatic F	ever 🛛 Polio
Immunizations and Dates	□ Tetanus :			Pneumonia:
	Hepatitis:			Chickenpox:
	Influenza:			MMR (Measles, Mumps, Rubella):

Prior Evaluations	Date	Unknown	Never
Bone Densitometry			
Sigmoidoscopy or Colonoscopy			
PSA (Prostate Screening)			
Mammogram			
PAP Screen			

 Females Only:
 Age Menstruation started _____
 Age Menstruation Stopped _____
 Still Menstruating _____

Irregular Periods / Heavy Bleeding	Yes	No	Severe Cramps	Yes	No
History of Abnormal Paps	Yes	No	Miscarriage	Yes	No
Hysterectomy: Partial / Complete	Yes	No	Have you ever given birth to a child	Yes	No

Past Medical History (surgeries, serious injuries/illness/hospitalizations)	Date:	

	Family Member	Deceased				Cause of Death	Currer Age	_	Health Status	
	Father	Yes	No							
	Mother	Yes	No							
	Brothers	Yes	No							
		Yes	No							
:	Sisters	Yes	No							
		Yes	No							
L	н	ave an	y of yo	our relatives	had any of t	he follow	ing?			
				ondition		Yes	No	Relationship		
High C	holesterol									
Diabet	es									
Kidney	Disease									
Heart I	Disease or	High Blo	ood Pre	ssure						
Osteop	orosis									
Asthma	a or Hay Fe	ever								
Colon I	Polyps									
Cancer	Cancer: Type									
Intellec	llectual Disability									
Birth D	efects									
Other	Disease:									
Geneti	enetic Counseling:									

	Date
NOD book	
Behavior Specialist	
Program Manager	
IPMG Case Manager	
QMRP	
Day Service Distribution	
MOD Book	

Health Record forwarded to...