OneVision
Connecting People with Purpose

Services Assessment

NAME: _____ **DATE ASSESSMENT COMPLETED:** _____

I. MEDICAL ASSESSMENT:

A. Medical Conditions:

☐Yes ☐No genito urinary
☐Yes ☐No respiratory
☐Yes ☐No cardiovascular
☐Yes ☐No diabetes
☐Yes ☐No gastrointestinal
☐Yes ☐No endocrine
☐Yes ☐No neurological/neuromuscular
☐Yes ☐No cancer
☐Yes ☐No immunological
☐Yes ☐No skeletal
☐Yes ☐No other _____

B. Does the person have a history of seizures?
☐Yes ☐No

C. Frequency of seizures:
☐ 0. none this year
☐ 1. less than one a month
☐ 2. once a month
☐ 3. about once a week
☐ 4. several times a week
☐ 5. once a day or more

D. Does the person have a vagal nerve stimulator for seizures? ☐Yes ☐No

E. Is the person currently taking prescription medications? ☐Yes ☐No

F. Does the individual receive medication by injection? ☐Yes ☐No

G. Level of support the person needs to take prescription medications and treatments:
☐0. no medications
☐1. independent
☐2. supervision
☐3. assistance
☐4. total support

H. The person's typical level of mobility:
☐0. walks independently
☐1. walks independently with difficulty, no corrective devices
☐2. walks independently with a corrective device
☐3. walks only with assistance of another person
☐4. cannot walk

I. Does the person use a wheelchair?□Yes□No If Yes, please answer next question:

J. Indicate the response that best describes wheelchair mobility:

☐ 0. can use wheelchair independently
☐ 1. can use wheelchair independently with assistance transferring
☐ 2. requires assistance in transferring and moving
☐ 3. no mobility, must be transferred and moved.

K. Does the person need a mechanical lift for transferring?□Yes □No

L. Does the person use special adaptive equipment, including but not limited to: a walker, wheelchair, prosthetic device/s, head protective device, crutches, hearing aids, glasses, AFO's, braces, splints, gait belt, communication devices, eating device/s?□Yes □No
Please circle as applicable or indicate other:

M. Indicate the response that best describes the number of health and medical appointments the person has a year:

☐0. 6 or less
☐1. 7 to 12
☐2. 13 or more

N. Does the person need OT evaluation and services? ☐Yes ☐No

O. Does the person need PT evaluation and services? ☐Yes ☐No

P. Does the person need Speech evaluation and services? ☐Yes ☐No

Q. Does the person require repairs to their wheelchair? ☐Yes ☐No

R. Does the person need support to complete physical therapy recommendations? ☐ Yes ☐ No

S. Do the person's needs require that the caregiver be trained in special health care procedures, including but not limited to: lifting and transferring, positioning, adaptive devices, hearing aids, seizure precautions, diabetic care, ostomy care? ☐Yes ☐No
Please circle as applicable or indicate other:

T. Presently requires special diet planned by the dietitian? ☐Yes ☐No

V. Was hospitalized for a medical problem in the last year? ☐Yes ☐No

W. Does the person need to be turned at night in bed? ☐Yes ☐No

II. BEHAVIOR ASSESSMENT

0 - not this year; 1 - less than once a month; 2 - about one time a month; 3 - weekly;
4 - several times a week; 5 – one time a day or more; Circle the number that applies.

A. Indicate the frequency of each behavior over the last twelve months.

Has emotional outbursts:	☐0	☐1	☐2	☐3	☐4	☐5
Damages own or other property:	☐0	☐1	☐2	☐3	☐4	☐5
Physically assaults others:	☐0	☐1	☐2	☐3	☐4	☐5
Disrupts others:	☐0	☐1	☐2	☐3	☐4	☐5
Is verbally and gesturally abusive:	☐0	☐1	☐2	☐3	☐4	☐5
Is self injurious:	☐0	☐1	☐2	☐3	☐4	☐5
Teases and harasses peers:	☐0	☐1	☐2	☐3	☐4	☐5
Resistive to staff supervision:	☐0	☐1	☐2	☐3	☐4	☐5
Runs or wanders away:	☐0	☐1	☐2	☐3	☐4	☐5
Steals:	☐0	☐1	☐2	☐3	☐4	☐5
Eats inedible objects:	☐0	☐1	☐2	☐3	☐4	☐5
Displays sexually inappropriate behavior	☐0	☐1	☐2	☐3	☐4	☐5
Smears feces:	☐0	☐1	☐2	☐3	☐4	☐5
Demands extra attention from staff:	☐0	☐1	☐2	☐3	☐4	☐5

B. As a result of any challenging or interfering behavior(s), consider whether or not the following presently apply:

☐Yes ☐No Does the person have a behavior program?

☐Yes ☐No Are medications prescribed for behavior or mental health management?

☐Yes ☐No The individual's environment must be carefully structured to avoid challenging or interfering behavior?

☐Yes ☐No Staff must sometimes intervene with the use of restraint procedures.

☐Yes ☐No Because of challenging or interfering behaviors, the person requires one-to-one supervision for many activities and tasks.

☐Yes ☐No Because of challenging or interfering behaviors, the person requires visual supervision until completely calm, due to elopement or hurting others when upset.

☐Yes ☐No Because of challenging or interfering behaviors, the person requires close supervision in community.

III. PERSONAL CARE ASSESSMENT

3 – Total support (dependent on others);
2 – Assistance (requires a lot of hand on help);
1 – Supervision (requires mainly verbal prompts);
0 – Independent (starts and finishes without any help or prompts at all).
Circle the number that applies. If a particular item is non-applicable, record a NA.

A. Indicate the best you can how independently the person typically performs each activity or task:

Pulling self up to standing:	☐3	☐2	☐1	☐0	☐NA
Toileting of bowels:	☐3	☐2	☐1	☐0	☐NA
Toileting bladder:	☐3	☐2	☐1	☐0	☐NA
Feminine hygiene:	☐3	☐2	☐1	☐0	☐NA
Taking a bath/shower:	☐3	☐2	☐1	☐0	☐NA
Brushing teeth/cleaning dentures:	☐3	☐2	☐1	☐0	☐NA
Brushing/combing hair:	☐3	☐2	☐1	☐0	☐NA
Selecting clothes for weather:	☐3	☐2	☐1	☐0	☐NA
Putting on clothes:	☐3	☐2	☐1	☐0	☐NA
Undressing self:	☐3	☐2	☐1	☐0	☐NA
Drinking from a cup/glass:	☐3	☐2	☐1	☐0	☐NA
Cutting food:	☐3	☐2	☐1	☐0	☐NA
Chewing and swallowing food:	☐3	☐2	☐1	☐0	☐NA
Feeding self:	☐3	☐2	☐1	☐0	☐NA
Shaving self:	☐3	☐2	☐1	☐0	☐NA
Making bed:	☐3	☐2	☐1	☐0	☐NA
Cleaning room:	☐3	☐2	☐1	☐0	☐NA
Doing laundry:	☐3	☐2	☐1	☐0	☐NA
Using telephone:	☐3	☐2	☐1	☐0	☐NA
Shopping for simple meal:	☐3	☐2	☐1	☐0	☐NA
Preparing foods that do not require cooking:	☐3	☐2	☐1	☐0	☐NA
Using stove or microwave:	☐3	☐2	☐1	☐0	☐NA
Crossing street in residential neighborhood:	☐3	☐2	☐1	☐0	☐NA
Using public transportation for a simple trip:	☐3	☐2	☐1	☐0	☐NA
Managing own money:	☐3	☐2	☐1	☐0	☐NA

Cyndi Reid, Services Coordinator
One Vision
PO Box 622
Clear Lake, IA 50428
O: 641-355-1345 M: 641-525-2981
creid@onevision.org