

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

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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: \_\_\_\_\_

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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.