IDD INDIVIDUAL ASSESSMENT

NAME:_____ CASE#: _____

D.O.B._ _____MALE_____FEMALE_____

PHYSICAL
ADDRESS:___ _____

___ _____TEXAS, ZIP CODE_____

CONTACT NUMBERS: (HOME) _____(CELL)_____

MAILING ADDRESS: (if different)_____

RESPONSIBLE PERSON/GUARDIAN _____RELATIONSHIP_____

EMAIL
ADDRESS:_____
(See handbook for encrypted email instructions)

MEDICAL INFORMATION

Allergies: Yes___No___ List All Allergies:_____
_____
EPI-Pen used: Yes____No_____(**this requires a Dr.s order with instructions, even if it's PRN**).

MEDICATION

Will you need your contract provider to assist in the administration of medication Yes____ No____.
(if yes, additional medication may be required from family or physician)

If so, I understand that it will be my responsibility to insure all medication information is shared with the Respite / Community Support provider and the provider is kept current of any changes. Medication Administration Training will be required of all contract providers that will monitor or assist in the administration of medication to any individual receiving Respite and/or Community Support services. For weekend Respite services, all medication information pertaining to Dosage, Frequency and Route must be provided by the physician on med sheet prior to date of scheduled Respite.

Are there any other medical/dental/behavioral conditions that the service providers should be aware of? (cholesterol or diabetes controlled by diet etc…)
Yes___No___Describe _____
_____
_____

Physical Handicaps ? Yes___No___Describe _____

_____

_____

Any Prosthetic devices or adaptive equipment ? Yes___No___Describe type and complete instructions for use._____

_____

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SEIZURES/CONVULSIONS

Has the individual ever had seizures or convulsions? Yes___No____

Does the individual currently have seizures or convulsions? Yes___No___

With medication _____seizures per _____

Without medication _____seizures per_____

Usual behaviors associated with individual seizure:

_____Convulsing ____Chewing/swallowing of tongue ____Loss of consciousness

_____Frothing of mouth ____Other _____

Describe actions to take during seizure _____
_____

Describe individual's behavior after seizure _____
_____

HYGIENE/PERSONAL HABITS

Is individual right handed? _____Left handed?_____ Both?_____

TOILETING:

_____Individual can use the toilet with no accidents (day or night) and can go without reminders.

_____Bowel Control ____Bladder Control ____Night Accidents

____Needs Assistance ____Needs Reminders ____Wears Diapers

How does the individual indicate the need to use the toilet?_____

BATHING: Usual time _____ (am) or (pm) Needs Assistance Yes___No___

BRUSHING TEETH: Usual time _____(am) or (pm) Needs Assistance Yes___No___

SLEEP PATTERNS:
Wake Time: _____ Bed Time:_____ Nap: _____

UNUSUAL SLEEP/BEDTIME HABITS: (sleep walk, night terrors, stays up late etc…)
(*Keep in mind the person receiving the respite will be required to sleep in his/her own room and will not share a room with any other individuals receiving weekend respite)*
_____
_____
_____

Describe actions taken
_____
_____

IDD INDIVIDUAL ASSESSMENT

NAME:_____ CASE#: _____

_____

DRESSING:

____Fully Independent ____Fully Dependent

____Requires Supervision Only ____Requires Assistance

EATING:

____Eats Independently ____Uses Utensils ____Requires Assistance

_____Other (cutting food into small bits, etc.)

FOOD ALLERGIES: Yes___No___ Describe _____

_____

Foods to Avoid _____

Favorite Foods _____

Special diet or food preparation required? Yes___No___ Describe _____
(family will provide all special dietary foods if needed)
_____

Usual eating times: Breakfast _____ Lunch _____ Dinner_____

Are there any unusual eating habits or concerns. (ie: only eats 2 times a day, takes time eating, eats too fast etc..)
_____
_____

COMMUNICATION

____Blind (fully/partially) ____Deaf (fully/partially)

____Uses easily understood speech ____Uses some speech

____Non-Verbal/Verbal ____Understands most speech

____Understands some speech ____Uses other methods of communication.

Additional Information _____

RECREATION

Activities the individual enjoys _____

Activities the individual dislikes_____

Activities encouraged _____

Physical Restrictions? Yes___No___ Describe_____

IDD INDIVIDUAL ASSESSMENT

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(**If attending Respite @ Lone Oak Ranch or utilizing our facility–Waiver Form will need to be completed**)

Is there any reason individual receiving respite could not participate in any activity away from the program.
_____
_____

BEHAVIOR CHALLENGES

Problematic behaviors that the individual shows _____

_____

Strategies/Reinforcers_____

_____

How does the individual react?

_____Changes behavior? _____Same behavior? _____Argues/Threatens?

How do you expect service providers to handle these behaviors?_____

_____

SOCIAL SUPPORTS

List all Household
Members_____

Friends _____

How does individual respond to family and friends? _____
_____

What behavior in people or things does the individual likes/dislikes? _____

_____

Does the individual have any fears? Yes___No___ Describe fear and how you expect provider to handle these fears (animals, loud noises etc..)
_____

_____

What are the individual's strengths? _____

NAME:_____ CASE#: _____

TRANSPORTATION

Please describe any special needs and/or procedures needed _____

_____

Please describe individual needs, service requests and other considerations or special information needed, if any.

_____

_____

_____

*****What trainings might be recommended for staff working with individual? _____**

_____

_____

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_____ Date _____
INDIVIDUAL/PARENT AND/OR GUARDIAN (Print Name)

_____ Date _____
INDIVIDUAL/PARENT AND/ORGUARDIAN (Signature)

_____ Date _____
WITNESS (if applicable-Print/Signature)

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ASSESSMENT COMPLETED and/or REVIEWED BY

Danielle Armknecht, IDD Provider of Services
Respite Program Supervisor
daniellea@gulfcoastcenter.org
(409) 944-4465/(800)-615-4763 ext. 19808

_____ _____
Signature(Staff) Date