Member Intake Form

Date___________
Desired Start Date______________ Circle one: **DTA DTS DTT**

Member Name____**Assist#**________________

Nickname ________________ **Date of Birth**__________ **Age**_____ **Gender F**____**M**____

Developmental Disability **Autism**_____ **Epilepsy**_____ **Intellectual**_____ **CP**_____

Family Home_____ **ADH**_____ **Group Home**_____ **IDLA**_____

Member Address ____
City State Zip

Home Phone________________________ Cell__________________________

Member/Guardian_______ Legal Guardian Assigned_______

Parent/Guardian Name(s)____

Address____
City State Zip

Home Phone________________________ Cell___________________________

DDD Support Coordinator ____

Work Number______________________ Cell__________________________

Emergency Contact Name_____________________________________ Relation__________

Cell________________________ Home/Work Phone___________________________

PCP or Health Care Facility____

Address____
City State Zip

Phone Number______________________

Primary Hospital____

Address____
City State Zip

Phone Number______________________

Pharmacy____
City State Zip

Phone Number______________________

Health Plan/Insurance Carrier____

Health - Medical

Seizures _____Yes _____No

_____Petit mal _____Completely controlled with medication

_____Grand mal _____Somewhat controlled with medication

_____Focal _____Not controlled with medication

Type________________ Frequency____________________ Approx. Duration______________

Unusual behavior **before** seizures (describe)____
____

Unusual behavior **after** seizures (describe)____
____

Recommended Response to Seizure Activity____
____

Assistive Devices

Hearing Aids___________ Vision Aids___________ Dental Appliances____________

Protective Devices_________________________ Purpose________________________

Instructional Use____

Other Individualized Health Care Routines____
____

Member Medical History

____Anemia	____Gall Bladder Problems	____Immune Disorder
____Asthma	____Gastritis	____Liver Disorder
____Blood Clots	____Head Trauma/Injury	____Migraine Headaches
____Cancer	____Heart Disease/Murmur	____Thyroid Disorder
____Chronic Bronchitis	____Hepatitis	____Ulcers
____Chronic Ear Infections	____High Blood Pressure	____Valley Fever
____Diabetes	____High Fever	
____Encephalitis	____Hydrocephalus	____None of the Above

Comments____

Allergies _____Yes _____No

Specify____

Allergy to food (specify)____
____

Allergy to bee stings (specify)____

Allergy to medications (specify)____

____

Stepping Stone Adult Development Center LLC
General Consent and Authorization

I, _______________________________ (member representative) certify that I am the legal responsible person of __________________________________ (member) and I consent to the following for him/her for a period not to exceed 12 months from the date of my signature.

______Yes ______No Necessary Emergency Medical treatment

_______Yes ______No Administration of over-the-counter medications (listed) and on-going medications prescribed by a physician or dentist and not to exceed the maximum dosage.

The preceding has been explained to me and I certify that I understand it fully. I also understand that my consent may be withdrawn at any time by my written notification.

____ Member Signature ________________ Date

____ Member Representative Signature ________________ Date

Medications (taken between 8:30-4:00pm at SS) **Dosage** **Frequency** (time of day)

____

____

____

____

____

____

____

____

____

All prescribed medication must be in prescription bottle with member name and up to date.

Emergency Contact Information (once again please)

Name____Cell___________________
Relationship__________________

Over the Counter/As Needed Medication Authorization Form

Next Page | Please have Physician signature

PRN Medication Authorization Form

Member____ **D.O.B.**__________________

Physician Please check PRNs that have your approval below.

Direct Care Staff Follow dosage instructions on medication label on container. List PRN and dosage on medication log.

_____ *Alka Seltzer*

_____ Acetaminophen

_____ Antacid

_____ Antibiotic Ointment

_____ Antidiarrheal

_____ Aspirin

_____ Claritin

_____ *Cortizone*

_____ Cough Drops/Syrup

_____ Dimetapp

_____ Eye Drops

_____ Hydrocortisone

_____ Hydrogen Peroxide

_____ Ibuprofen

_____ Milk of Magnesia

_____ Nasal Spray

_____ *Pepto-Bismol*

_____ *Tums*

Additional PRN medications approved by physician

____

____

____

____

Generic or store brand medications are acceptable unless otherwise noted.

Physician Signature____Date___________________

Parent/Guardian Signature__________________________________Date__________________

Nutrition – Diet

Special Diet/Health Concerns____
____

Food

_______Independent _______Prompt _______Requires Help _______Significant Assistance

Independent with eating utensils _______Yes _______No
Requires limited assistance _______Yes ______No
Significant assistance needed _______Yes _______No

Sugar Allowed
_______Yes _______No

Consistency of food _______Normal _______Chopped _______Pureed

Choking hazard _______Yes _______No

Beverages
Independent with cup _______Yes _______No
Requires assistance/straw _______Yes _______No
Significant assistance needed _______Yes _______No

Caffeine Drinks Allowed
Tea _______Yes _______No
Coffee _______Yes _______No
Soda _______Yes _______No

Independent obtaining/requesting beverages _______Yes _______No

Personal Care

	Toilet	**Menses**
Independent	_____	______
Prompting	_____	______
Requires Assistance	_____	______
Significant Assistance	_____	______

Mobility
_____ Independent
_____ Wheelchair
_____ Walker
_____ Crutches
_____ Fall Risk

Comments____
____
____

Communication Skills

Communication Modes

______Verbal _______Device _______Sign _______Gesture _______

Comments____
____

Expressive Language

_______Articulate _______Single Words _______Asks for help _______Problems Articulating

Receptive Language

_______Comprehends _______Follows 3+step instructions _______Direct 1 step at a time

Comments____
____
____

Social/Emotional Development

_______Relatively free from signs of problems

_______Interacts appropriately with caregivers

_______Interacts appropriately with peers

_______Interacts appropriately with animals **Fear of dogs** _____Yes _____No

Expresses feelings _______Verbally _______Non-verbally

_______Initiates cooperative interactions

_______Usually even-tempered

_______Shows anger appropriately

_______Doesn't interact even when encouraged

_______Resists cooperation

_______Appears to have significant emotional problems

Prefers the company of

_______Males _______Females _______Peers _______Staff _______No preference

Comments____
____
____
____
____

Behavioral Concerns		Describe	Frequency
Aggression	____Yes ____No		
Self-Injurious	____Yes ____No		
Injurious toward others	____Yes ____No		
Property destruction	____Yes ____No		
Unusual repetitive behavior	____Ye ____No		
Self-stimulating (stimming)	____Yes ____No		
Running away	____Yes ____No		
Sexual acting out	____Yes ____No		
Other	____Yes ____No		

Comments____

____
____
____

✓ **Members Likes** (Please add information to better care for our members)

_______Animals____

______Arts and Crafts____

______Board Games____

______Card Games____

______Community Activities____

______Computer____

______Dancing____

______Drawing/Coloring____

______Exceptional Interest____

______Movies____

______Music Favorites____

______Shopping/Stores____

______Snacks and Drinks____

______Sports____

______Subjects in School____

______Theater/Acting____

______TV Shows____

______Video Games____

_______Word Search____

Photo Consent and Release

I, ______________________________________ (member representative) certify that I am legally responsible person of ___________________________________ (member) and I consent to the following for him/her for a period not to exceed 12 months from the date of my signature.

_____Yes _____No Permission to be photographed at the program and/or on outings in the community

If "Yes", the photos may be used for the following purposed only:

_____On site activities i.e. crafts, album, in day program
_____Brochures, pamphlets, advertising information
_____Website
_____Outside resources i.e. for a member's iPad PECS

This has been explained to me and I certify that I fully understand. I also understand that my consent may be withdrawn at any time by my written notification.

____ ______________
Member Signature Date

____ ______________
Member Representative Signature Date