SOUTHEASTERN RESIDENTIAL RESPITE SERVICES

Massachusetts Department of Developmental Services

(1) Entry Date: _____

(2) Entered By: _____

(To be completed or updated by the individual's guardian/family/provider)

BASIC INFORMATION

(3) Name: _____

(4) D.O.B: _____ **(5)** Gender: _____ **(6)** SSN: _____

(7) Address Line 1: _____

(8) Address Line 2: _____

(9) City: _____ **(10)** State: ____ **(11)** Zip: _____

(12) Telephone: _____

(13) Language: _____

(13A) Do you need an interperter: ❑ Yes ❑ No

(13B) Likes to be called**:** _____

(14) Religion: _____

Health Insurance (type & numbers) (Provide copies of cards.)

(15A) Ins. #1: ___ **(15B)** #: _

(16A) Ins. #2: _____ **(16B)** #: _____

(17A) Ins. #3: _____ **(17B)** #: _____

(18A) Ins. #4: _____ **(18B)** #: _____

(19) Agency Responsible for Provider Care? ❑ No ❑ Yes **(19A)** _____ **(19B)** Tel. #: _____
Name of agency/primary contact person

(20) Consent Status: ❑ Can give own consent ❑ Consent from guardian ❑ Unable to give own consent and no guardian

(20A) If Consent from Guardian, Guardian Name: _____ **(20B)** Tel. #: _____ (copy of decree needed)

(20C) If Power of Attorney, Attorney Name: _____ **(20D)** Tel. #: _____ (copy of decree needed)

(21) Resuscitation Status: ❑ DNR (Copy Needed) ❑ Full Resuscitation

(21A) If DNR is comfort care available? ❑ Yes ❑ No ❑ Unknown

(22) Health Care Proxy: ❑ Yes ❑ No ❑ Unknown **(22A)** Name: _____ **(22B)** Tel. #: _____

(23) Additional Comment regarding the individual's medical condition or state: _____

_____

CONTACTS – EMERGENCY AND PHARMACY

(Repeat 24A – 24H for additional emergency/pharmacy contacts on separate sheet)

(24A) Type *Select One*	(24B) Name	(24C) Street Address	(24D) City	(24E) State	(24F) Zip	(24G) Telephone	(24H) Fax
❑ Emergency ❑ Pharmacy							
❑ Emergency ❑ Pharmacy							
❑ Emergency ❑ Pharmacy							
❑ Emergency ❑ Pharmacy							

MEDICATIONS LIST

(Repeat 25A – 25E for additional medications on separate sheet)

Frequency Options:

- 1 x day
- 2 x day
- 3 x day
- 4 x day
- Once every other day
- 1 x week
- 2 x week
- Once every 28 days
- Every 2 Months
- Every 3 Months
- Every 6 Months
- Annually
- PRN
- Unknown

(25A) Medication Name	(25B) Reason for Prescription	(25C) Frequency *Select one from above*	(25D) Date Started	(25E) Date Stopped

Individual's Name:_____

ALLERGIES:

(26A) Type	(26B) To What?	(26C) Type of Reaction
❑ Food ❑ Medication ❑ Environmental ❑ Insects ❑ Other		

***Please attach recent History and Physical to include Diagnosis and Associated Medical Problems.

CURRENT MEDICAL PROBLEMS AND DIAGNOSES *(Select all that apply)*

(27) Neurologic:
❑ Cerebral Palsy ❑ Epilepsy / Seizure Disorder ❑ Alzheimer's Disease ❑ Other - If Other, specify: _____

(28) Cardiovascular:
❑ Coronary Artery Disease ❑ Congestive Heart Failure ❑ Hypertension ❑ Other - If Other, specify: _____

(29) Respiratory:
❑ Pneumonia ❑ Asthma ❑ COPD ❑ Recurrent Infection ❑ Aspiration ❑ Other - If Other, specify: _____

(30) Gastrointestinal:
❑ GERD ❑ Dysphagia ❑ Constipation ❑ Other - If Other, specify: _____

(31) Musculoskeletal:
❑ Arthritis ❑ Osteoporosis ❑ Other - If Other, specify: _____

(32) Kidney/Urinary:
❑ Renal Insufficiency / Failure ❑ Urinary Retention ❑ Recurrent Infection ❑ Other - If Other, specify: _____

(33) Cancer/Neoplasm:
❑ Lung Cancer ❑ Colon Cancer ❑ Liver Cancer ❑ Brain Cancer
❑ Prostate Cancer ❑ Esophageal Cancer ❑ Blood Cancer ❑ Other
❑ Stomach Cancer ❑ Pancreatic Cancer ❑ Breast Cancer If Other, specify: _____

(34) Metabolic/Endocrine:
❑ Diabetes ❑ Hyperlipidemia ❑ Hyperthyroidism ❑ Hypothyroidism ❑ Other - If Other, specify: _____

(35) Syndromes:
❑ Autistic Disorder ❑ Cornelia DeLange syndrome ❑ Rett Syndrome ❑ Velocardiofacial Syndrome (DiGeorge)
❑ Down Syndrome ❑ Fetal Alcohol Syndrome ❑ Smith-Magenis syndrome ❑ Williams Syndrome
❑ Prader-Willi ❑ Fragile X ❑ Tuberous Sclerosis ❑ Other
❑ Angelman syndrome ❑ Phenylketonuria (PKU) ❑ Turner's Syndrome If Other, specify: _____

(36) Psychiatric:
❑ Anxiety disorder - Generalized Anxiety ❑ Impulse Control Disorder ❑ Personality Disorder - Antisocial ❑ Sexual disorders
❑ Anxiety disorder - OCD ❑ Mental disorder due to medical problem - related to seizure disorder ❑ Personality Disorder - Borderline ❑ Substance use disorder
❑ Anxiety disorder - Panic Disorder/agoraphobia ❑ Mental disorder due to medical problem - related to medication side effects ❑ Personality Disorder - Paranoid ❑ Other
❑ Anxiety disorder - PTSD ❑ Mood disorder - Bipolar disorder ❑ Schizophrenia and thought disorders If Other, specify: _____
❑ Dementia related disorders ❑ Mood disorder - Depressive disorder ❑ Psychotic Disorder not otherwise specified

(37) General Medical Problems: _____
_____

FUNCTIONAL STATUS *(Select all that apply)*

(38) Communication: ❑ Able to Communicate ❑ Communication Difficulties/Uses Verbalizations
❑ Communication Difficulties/Uses Gestures ❑ Not Able to Communicate Needs ❑ Unable to Use Call Bell
❑ Only speaks/understands foreign language _____ ❑ Sign Language ❑ Unknown

(38A) What are the individual's pain indicators? (for example: none, cries, withdraws, gestures, etc.):_____

(38B) When individual is not feeling well, how is that usually communicated? (for example: withdraws, gestures to area bothering him, loss of appetite, increase/decrease in usual behaviors, etc.):
_____

(38C) What are some atypical responses to illness or a physical problem for this individual? (for example: increase seizures with constipation or urinary tract infections, increased behaviors with developing bowel obstruction, hits to head and face with ear or sinus infection, etc.) _____

(39) Vision: ❑ Normal ❑ Low Vision ❑ Blind ❑ Wears Glasses ❑ Unknown

Individual's Name:_____

(40) Supportive Devices: ❑ Durable Medical Equipment_____
❑ Padded side rails ❑ Splints ❑ Braces ❑ Helmet ❑ Other _____ ❑ Unknown ❑ None

(40A) Bed: type used_____ **(40B) Safety Assessment on bed/supports completed?**

(41) Hearing: ❑ Normal ❑ Hard of Hearing ❑ Deaf ❑ Hearing Aid ❑ Unknown

(42) Toileting Ability: ❑ Continent ❑ Needs Assistance ❑ Incontinent ❑ Catheterized ❑ Other ❑ Unknown

(43) Medication Administration: ❑ Independent/Self Medicates ❑ Medication Administered by Staff ❑ Unknown

(43A) How is medication taken? (for example, with applesauce, crushed, via tube, etc.) _____

(44) Dining/Eating:
❑ Independent ❑ Needs Assistance ❑ Totally Dependent ❑ Fed Through a Tube ❑ Other ❑ Unknown

(45) Diet Texture: ❑ Regular ❑ Chopped ❑ Ground ❑ Puree ❑ Thicken Liquid ❑ Unknown

(46) Diet Type: _____

(46A) Equipment Needs for Meals: Explain:_____

(46B) Mealtime Guidelines: Explain:_____

(47) Ambulation:
❑ Independent-Steady ❑ Independent-Unsteady ❑ Needs Assistance-1 person ❑ Needs Assistance-2 people or more
❑ Ambulation Aids - Walker ❑ Ambulation Aids - Cane ❑ Ambulation Aids - Crutches ❑ Ambulation Aids - Wheelchair
❑ Non-Ambulatory ❑ Unknown ❑ Other: _____
(47A) If wheelchair: ❑ Owns own wheelchair? **(47B)** Date wheelchair acquired: _____

(47C) If Activities restricted, explain: complete bed rest, bed rest with BRP, transfer to bed/chair, partial weight bearing, independent at home, other (Specify)_____

(47D) Exercises Prescribed (Explain): _____

(48) Personal Hygiene: ❑ Independent ❑ Special Needs **If yes, explain:** _____ ❑ Unknown

(49) Oral Hygiene: ❑ Independent ❑ Special Needs **If yes, explain:** _____ ❑ Unknown

(50) Head of Bed Elevated: ❑ Yes ❑ No If yes, explain _____

(51) Any previous problems with anesthesia? ❑ Yes ❑ No
(51A) If yes, explain: _____

SPECIAL NEEDS *(Select one)*

(52) Usual response to Medical Exams: ❑ Cooperates ❑ Partially Cooperates ❑ Resistant ❑ Fearful ❑ Unknown

(53) Sedation for clinical visits: ❑ Yes ❑ No ❑ Unknown

(53A) If Yes, what type of clinical visits: _____ **(53B)** If Yes, type of sedation used: _____

(54) Special positioning required for examination: ❑ Yes ❑ No ❑ Unknown **(54A)** If Yes, Explain: _____

(55) Double staffing required for assistance with exams: ❑ Yes ❑ No ❑ Unknown **(55A)** If Yes, Explain: _____

(56) Requires limited waiting periods for exams: ❑ Yes ❑ No ❑ Unknown

(57) Appointment Schedule Preference: ❑ Early day ❑ End of day ❑ Unknown ❑ No Preference

(58) Special communication device/method: ❑ Yes ❑ No ❑ Unknown **(58A)** If Yes, (Explain): _____

(59) Pain Response: ❑ Normal ❑ Unique ❑ Unknown **(59A)** If Unique, Explain: _____

(60) Signs of Discomfort: ❑ Yes ❑ No ❑Unknown **(60A)** If Yes, Explain: _____

CONTACTS - HEALTHCARE PROVIDERS *(Repeat 61A – 61H for additional healthcare providers contacts on separate sheet)*

(61A) Type/Specialty	(61B) Name	(61C) Street Address	(61D) City	(61E) State	(61F) Zip	(61G) Telephone	(61H) Fax

DEMOGRAPHICS

(62) Living Status: ❑ Family ❑ Group Home ❑ Independent ❑ Home Sharing/Shared Home
(Select one) ❑ Other _____

(63) Marital Status *(Select one)*: ❑ Single ❑ Married ❑ Other-Widow ❑ Divorced ❑ Legally Separated

(64) Work/Day Program Status: *(Select all that apply)*
❑ Community Day Support ❑ Day Habilitation ❑ Regular job ❑ Sheltered ❑ Unknown

(65) Nursing Supports available: *(Select all that apply)*
❑ In home less than 24 hr ❑ In home 24 hr ❑ Healthcare Coordination ❑ VNA services may be available
❑ At Day Program ❑ No Nursing Supports ❑ Unknown

IMMUNIZATIONS / TB TESTING

(66) Date of most recent TETANUS: _____ ❑ Administered ❑ Unknown ❑ Allergic ❑ Never

(67) Date of most recent FLU SHOT: _____ ❑ Administered ❑ Unknown ❑ Allergic ❑ Never

(68) Date of most recent PNEUMOVAX: _____ ❑ Administered ❑ Unknown ❑ Allergic ❑ Never

(69) Dates of HEPATITIS B VACCINE:

(69A) Primary Series (last administered): _____ ❑ Series Complete ❑ Administered ❑ Unknown ❑ Allergic ❑ Never

(69B) Booster: _____ ❑ Administered ❑ Unknown ❑ Allergic ❑ Never

(70) Dates most recent MEASLES/MUMPS/RUBELLA (MMR): _____ ❑ Administered ❑ Unknown ❑ Allergic ❑ Never

(71) List any other vaccinations and dates (e.g., Lyme Hepatitis A, Varicella, etc.): _____

_____

Tuberculosis Skin Test (PPD):

(72) Has the individual ever had a positive skin test for tuberculosis? ❑ Yes ❑ No ❑ Unknown

(72A) If Yes, was any treatment given? ❑ Yes ❑ No ❑ Unknown

(72B) If Yes, please describe. If No, please explain why treatment was not given: _____

_____

(73) Date of last PPD: _____ **(73A)** If unknown, explain: _____

PAST MEDICAL HISTORY – DDS RELEASE CONTACT

(74) ❑ Medical History not released by parent/guardian

For information, contact: *(Repeat 74A – 74G for additional contacts on separate sheet)*

(74A) Name	(74B) Relationship	(74C) Street Address	(74D) City	(74E) State	(74F) Zip	(74G) Telephone

PAST MEDICAL HISTORY – SURGICAL, TRAUMA AND HOSPITALIZATIONS

(Repeat 75A – 75E for additional events on separate sheet)

(75A) Type of Event (Select one)	(75B) Type of Hospitalization	(75C) Hospital Name	(75D) Description of Event	(75E) Date/Year of Event
❑ Broken Bones ❑ Serious Trauma ❑ Other	❑ Medical ❑ Surgical ❑ Psychiatric			
❑ Broken Bones ❑ Serious Trauma ❑ Other	❑ Medical ❑ Surgical ❑ Psychiatric			
❑ Broken Bones ❑ Serious Trauma ❑ Other	❑ Medical ❑ Surgical ❑ Psychiatric			

Individual's Name:_____

PAST MEDICAL HISTORY – GYNECOLOGIC (women only)

(76) Age menstruation started (women only): _____ ❑ Unknown

(77) Still menstruating: ❑ Yes ❑ No **(77A)** If No, age menstruation stopped: _____ ❑ Unknown

(78) Has individual ever given birth to a child? ❑ Yes ❑ No ❑ Unknown

(79) Gynecological exam status: ❑ Administered – Date: _____ ❑ Never conducted ❑ Unknown

(80) PAP Smear Status: ❑ Administered – Date: _____ ❑ Never conducted ❑ Unknown

(81) Any history of abnormal PAP smear? ❑ Yes ❑ No **(81A)** If Yes please describe: _____

(82) Mammogram Status: ❑ Administered – Date: _____ ❑ Never conducted ❑ Unknown

PAST MEDICAL HISTORY – MEDICAL AND PSYCHIATRIC *(Select all that apply)*

(83) Neurologic: ❑ Other - If Other, specify: _____

(84) Cardiovascular: ❑ Other - If Other, specify: _____

(85) Respiratory: ❑ Pneumonia ❑ Aspiration ❑ Other - If Other, specify: _____

(86) Gastrointestinal: ❑ GERD ❑ Dysphagia ❑ Constipation ❑ Other - If Other, specify: _____

(87) Musculoskeletal: ❑ Other - If Other, specify: _____

(88) Kidney/Urinary: ❑ Renal Insufficiency / Failure ❑ Urinary Retention ❑ Recurrent Infection ❑ Other - If Other, specify: _____

(89) Cancer/Neoplasm:

❑ Lung Cancer	❑ Colon Cancer	❑ Liver Cancer	❑ Brain Cancer
❑ Prostate Cancer	❑ Esophageal Cancer	❑ Blood Cancer	❑ Other - If Other, specify: _____
❑ Stomach Cancer	❑ Pancreatic Cancer	❑ Breast Cancer	

(90) Metabolic/Endocrine:

❑ Diabetes ❑ Hyperlipidemia ❑ Hyperthyroidism ❑ Hypothyroidism ❑ Other - If Other, specify: _____

(91) Psychiatric:

❑ Anxiety disorder - Generalized Anxiety	❑ Impulse Control Disorder	❑ Personality Disorder - Antisocial	❑ Sexual disorders
❑ Anxiety disorder - OCD	❑ Mental disorder due to medical problem - related to seizure disorder	❑ Personality Disorder - Borderline	❑ Substance use disorder
❑ Anxiety disorder - Panic Disorder/agoraphobia	❑ Mental disorder due to medical problem - related to medication side effects	❑ Personality Disorder - Paranoid	❑ Other
❑ Anxiety disorder - PTSD	❑ Mood disorder - Bipolar disorder	❑ Schizophrenia and thought disorders	If Other, specify: _____
❑ Dementia related disorders	❑ Mood disorder - Depressive disorder	❑ Psychotic Disorder not otherwise specified	_____
			_____

PAST MEDICAL HISTORY – EVALUATIONS

(92) AUDIOLOGICAL EXAM Status:	❑ Administered – Date: _____	❑ Never	❑ Unknown
(93) EYE EXAM Status:	❑ Administered – Date: _____	❑ Never	❑ Unknown
(94) DENTAL EXAM Status:	❑ Administered – Date: _____	❑ Never	❑ Unknown
(95) PHYSICAL EXAM Status:	❑ Administered – Date: _____	❑ Never	❑ Unknown
(96) BONE DENSITOMETRY (bone thickness) Status:	❑ Administered – Date: _____	❑ Never	❑ Unknown
(97) SIGMOIDOSCOPY or COLONSCOPY Status:	❑ Administered – Date: _____	❑ Never	❑ Unknown
(98) PSA (prostate cancer screening) Status:	❑ Administered – Date: _____	❑ Never	❑ Unknown

Individual's Name:_____

FAMILY HISTORY (Part 1)

(99) FATHER - Is Biological Father Known? ❑ Yes ❑ No

(100) If yes, deceased? ❑ Yes ❑ No ❑ Unknown

(100A) If Deceased, age at death: _____

(100B) If Deceased, cause of death: _____

(100C) If Not Deceased, year of birth: _____

(101) MOTHER - Is Biological Mother Known? ❑ Yes ❑ No

(102) If yes, deceased? ❑ Yes ❑ No ❑ Unknown

(102A) If Deceased, age at death: _____

(102B) If Deceased, cause of death: _____

(102C) If Not Deceased, year of birth: _____

(103) List all brothers and sisters with information about their age and health: _____

FAMILY HISTORY (Part 2)

Is there any family history of:

(104) DIABETES: ❑ Yes ❑ No ❑ Unknown

(105) HIGH CHOLESTEROL: ❑ Yes ❑ No ❑ Unknown

(106) OSTEOPOROSIS: ❑ Yes ❑ No ❑ Unknown

(107) CANCER: ❑ Yes ❑ No ❑ Unknown

(107A) If Yes, what Type: _____

(108) HIGH BLOOD PRESSURE: ❑ Yes ❑ No ❑ Unknown

(109) HEART DISEASE: ❑ Yes ❑ No ❑ Unknown

(110) COLON POLYPS: ❑ Yes ❑ No ❑ Unknown

(111) Are there any other diseases that "run in the family"? ❑ Yes ❑ No ❑ Unknown

(111A) If yes, explain: _____

(112) Has there been any genetic counseling in the family? ❑ Yes ❑ No ❑ Unknown

(112A) If yes, what were the results? _____