

**DDS RESPITE CENTER PACKET**

Attachment A

Select REGION

**REQUEST FOR RESPITE SERVICES**

(Completed by case manager or service coordinator)

**Request Date:** \_\_\_\_\_

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

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

**DDS #:** \_\_\_\_\_

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

**City/State:** \_\_\_\_\_

**Zip Code:** \_\_\_\_\_

**Current Residence:**  Family Home  CTH  DCF Foster Home  Other: \_\_\_\_\_

**Family/Caregiver Name:** \_\_\_\_\_

**Telephone:** (\_\_\_\_) \_\_\_\_\_

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

**City/State:** \_\_\_\_\_

**Zip Code:** \_\_\_\_\_

**ISA:**  NO  YES If yes, ISA amount: \$ \_\_\_\_\_ ISA is for: \_\_\_\_\_

**Individual & Family Need Checklist Points:** \_\_\_\_\_ **Residential WL Priority:** 0

**Respite Request for Select Center**

**Reason for this request:** \_\_\_\_\_

**List the exact dates and times:**

	Location	Start Date	Time	AM/PM	End Date	Time	AM/PM
<b>Choice #1</b>	<a href="#">Click Here</a>	_____	_____	<input type="checkbox"/> AM/ <input type="checkbox"/> PM	_____	_____	<input type="checkbox"/> AM/ <input type="checkbox"/> PM
<b>Choice #2</b>	<a href="#">Click Here</a>	_____	_____	<input type="checkbox"/> AM/ <input type="checkbox"/> PM	_____	_____	<input type="checkbox"/> AM/ <input type="checkbox"/> PM
<b>Choice #3</b>	<a href="#">Click Here</a>	_____	_____	<input type="checkbox"/> AM/ <input type="checkbox"/> PM	_____	_____	<input type="checkbox"/> AM/ <input type="checkbox"/> PM
<b>Choice #4</b>	<a href="#">Click Here</a>	_____	_____	<input type="checkbox"/> AM/ <input type="checkbox"/> PM	_____	_____	<input type="checkbox"/> AM/ <input type="checkbox"/> PM

**Case Manager or Service Coordinator:** \_\_\_\_\_

**Office Location:** \_\_\_\_\_

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

**Please DO NOT write below this line**

**Authorization Status:**  Approved  Denied  Modified  Pending

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

**Family Respite Center Coordinator's Signature:** \_\_\_\_\_

**Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Cc: FRC, Ind. File, Respite File

Name: \_\_\_\_\_

DDS#: \_\_\_\_\_

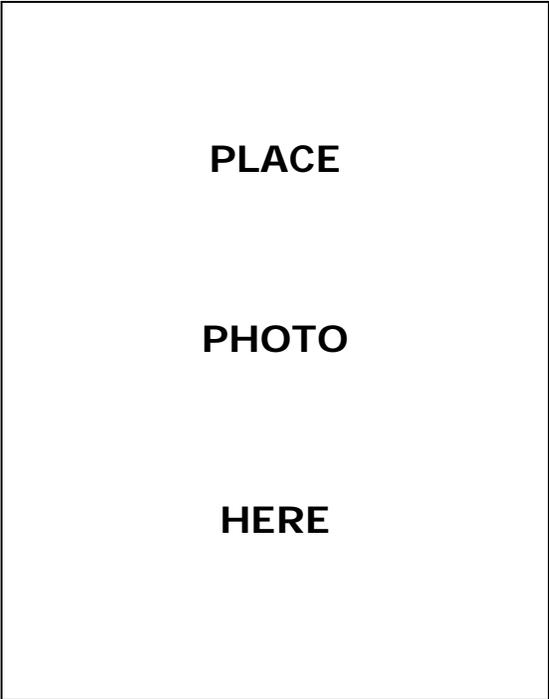
Original Pre-visit

Center: \_\_\_\_\_ Date: \_\_\_\_\_

**DDS RESPITE CENTER PACKET  
Select Region**

**GUEST PROFILE**

(Completed by CM/SC or SMRW at Pre-Visit)



Date: \_\_\_\_\_ D.O.B: \_\_\_\_\_ Nickname? \_\_\_\_\_

Hair Color: \_\_\_\_\_ Eye Color: \_\_\_\_\_ Height: \_\_\_\_\_ Wt: \_\_\_\_\_

Communication: Verbal:  Non-Verbal:  Religion: \_\_\_\_\_

Language spoken-understood, method, or device used:

Visually Impaired? Yes  No  Hearing Impaired? Yes  No

Level of Retardation: Mild  Moderate  Severe  Profound

Brief Medical Diagnosis: \_\_\_\_\_

Routine Medications? Yes  No  (refer to physician's orders)

If yes, how taken? \_\_\_\_\_

**Seizures:** Yes  No

If yes, describe type, frequency, and duration: \_\_\_\_\_

**Allergies:** Yes  No

If yes, please specify: \_\_\_\_\_

Describe feeding techniques used and adaptive equipment used:  
\_\_\_\_\_

**Food and Drink Issues:**

**Eats:** Independently  With Assist  Fed

**Drinks:** Independently  With Assist  Fed

**Utensils:** Fork  Knife  Spoon

Right handed?  Left handed?

Enjoys eating? Yes  No  Drinking? Yes  No

Portion sizes: \_\_\_\_\_

**Diet:** Regular:  Special:  If special, please specify: \_\_\_\_\_

**Restricted:** No  Yes  If yes, list restrictions: \_\_\_\_\_

**Supplements:** No  Yes  If yes, list restrictions: \_\_\_\_\_

**Consistency of Food:** Whole  Cut  Chopped  Ground  Pureed

**Consistently of Liquids:** Thin  Nectar  Honey  Pudding

List Exceptions: \_\_\_\_\_

Typical Breakfast Foods: \_\_\_\_\_

Typical Lunch Foods: \_\_\_\_\_

Typical Dinner Foods: \_\_\_\_\_

Typical snack and approximate times eaten: \_\_\_\_\_

Favorites: \_\_\_\_\_

Dislikes: \_\_\_\_\_

Special Instructions: \_\_\_\_\_

**Aspiration precautions:**  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**FOR INDIVIDUALS WHO ARE TUBE FED:**

Tube Fed only? \_\_\_\_\_ Tube fed liquids only? \_\_\_\_\_ Tube fed with meds? \_\_\_\_\_ Tube fed as a supplement? \_\_\_\_\_

Liquids Thickened? \_\_\_\_\_ Additional information: \_\_\_\_\_

Name: \_\_\_\_\_  
DDS: \_\_\_\_\_

**DDS RESPITE CENTER PACKET:  
GUEST PROFILE**

**Adaptive/Special Equipment:**

G-Tube  Oxygen  Tracheotomy  Ostomy Appliance  Nebulizer  Other  : \_\_\_\_\_  
Glasses  Hearing Aid  Walker  Wheelchair  Seatbelt for Wheelchair  Tray  OT/PT  
 Other  : \_\_\_\_\_  
AFO's(describe): \_\_\_\_\_

**Personal Care: Check level of care and describe assistance and equipment required**

Grooming: Self  With Assist  Total Care  \_\_\_\_\_  
Dressing: Self  With Assist  Total Care  \_\_\_\_\_  
Bathing: Self  With Assist  Total Care  \_\_\_\_\_  
Toileting: Self  With Assist  Total Care  \_\_\_\_\_

**Bathing Support Required:** No  Yes  If yes, check all that apply: **(please see attachment G for more information)**

Regulating water temperature and/or amount of water  entering or leaving tub  keeping head above water   
cleaning body  drying and dressing   
Type of Supervision Required: Independent , Continuous , Frequent checks (amount of time person can be alone= \_\_\_\_\_min)

**Individual uses the toilet:** No  Yes

**Toileting Support Required:** No  Yes

If yes, check all that apply: remove clothing , getting onto toilet,  personal hygiene afterwards, .  
If female, assistance during menses? No  Yes  N/A  If male, sits only on the toilet? No  Yes   
Requires reminders for hygiene? \_\_\_\_\_  
Diapered? Yes  No  At all times? Yes  No  Bed time only? Yes  No  Long trips only? Yes  No   
Time tripped? Yes  No  Tripping Schedule: Day time \_\_\_\_\_ Night time \_\_\_\_\_

**Is there a constipation problem?** No  Yes  **If yes, explain:** \_\_\_\_\_

**Special instructions / Adaptive Equipment pertaining to Toileting:** \_\_\_\_\_  
\_\_\_\_\_

**Behavior and Socialization:**

**Behavioral Concerns:** (check  all that apply)

Wanders , Bolts , Self-abuse , Head butts , Aggression to Environment , Aggression to Others , Bites   
Hits , Kicks , Mouths Objects , Obsesses , Verbally Abusive , Screams  Drops to Floor , Steals Food   
Generally Non-Compliant  Hyperactivity  Depression , Removes seatbelt during transportation ,  
Grabs/Inappropriate Touches Others , **PICA:** No  Yes  **(If yes, refer to attachment P)**  
Hallucinations: (Auditory , Visual , Tactile  ) Paranoid , Tantrums , Anxiety ,

Special Instructions/Restrictions Problems with noise or crowds: \_\_\_\_\_  
What circumstances might encourage such behaviors? \_\_\_\_\_  
Length of time behaviors usually persist: \_\_\_\_\_ min/hrs. Frequency: Day: \_\_\_\_\_ Week: \_\_\_\_\_  
Major life changes related to behavioral concerns: \_\_\_\_\_  
Behaviors to be encouraged: \_\_\_\_\_  
Typical means of interaction with others: \_\_\_\_\_  
Ethnic or Religious concerns/restrictions: \_\_\_\_\_  
Smokes? \_\_\_\_\_ (Explain any special guidelines, how much, how often, and when) \_\_\_\_\_

**Sleep Habits:**

Bedtime: \_\_\_\_\_ Awakens: \_\_\_\_\_ Sleeps through?: \_\_\_\_\_ Awakens often?: \_\_\_\_\_ Frequency: \_\_\_\_\_  
**Type of Bed:** \_\_\_\_\_ **Bed rails:** Yes  No  **Night Light?** Yes  No  **Pads?** Yes  No  **Why?** \_\_\_\_\_

Special instructions, favorite bedtime articles, rituals or problem areas associated with sleep: \_\_\_\_\_  
\_\_\_\_\_

**Positioning Required?:** Yes  No . If yes, explain reason position used and/or frequency (I.E. reflux means head of the bead must be increased) \_\_\_\_\_  
\_\_\_\_\_

Other: \_\_\_\_\_

**Favorite Activities:** At home: \_\_\_\_\_

In community: \_\_\_\_\_





Name: \_\_\_\_\_  
 DDS#: \_\_\_\_\_

**DDS RESPITE CENTER PROGRAM**  
 Select REGION

**EMERGENCY AND AUTHORIZATION FORM**  
 (Completed by CM/SC or SMRW)

Respite Center Phone ( ) \_\_\_\_\_-\_\_\_\_\_

**EMERGENCY INFORMATION**

Name:	DOB:	DDS#:
Address:	Phone#:	
Parent/Guardian:	Day Phone#:	
Address:	Eve. Phone#:	
DDS Case Manager:	Phone:	
Day Program:	Phone#:	
Address:		
Emergency Contact (Other than parent/guardian):	Day Phone#:	
Address:		
<b>Primary Physician:</b>		
Address:	Phone#:	
Hospital Choice:	Address:	Phone#:
Neurologist:		
Address:	Phone#:	
Psychologist/Psychiatrist:		
Address:	Phone#:	
Dentist:		
Address:	Phone#:	
Name of Insurance:	Policy Number:	
Pharmacy:		
Address:	Phone#:	

**MEDICAL AUTHORIZATION FORM**  
 (Completed by Guest/Family member/Guardian)  
 Authorization for Medical Treatment

In the event that I cannot be reached, I hereby give consent for \_\_\_\_\_  
 (Physician/Medical Facility)  
 to provide medical care for \_\_\_\_\_ D.O.B. \_\_\_\_\_ for treatment of  
 illness or injury. If medication is prescribed, I hereby authorize: \_\_\_\_\_

\_\_\_\_\_  
 (Name and Address of Pharmacy) (Phone)

**Insurance Name and Number**  
 To fill the prescription and charge my insurance.

\_\_\_\_\_  
 (Signature of Consumer/Parent/ Legal Guardian) (Date)

**DISCLOSURE**

" I understand that door chimes may be used at the Respite Center to indicate when people may be entering and leaving." Please let the Respite Center Staff know if the chimes would present a problem for your family member.

\_\_\_\_\_  
 (Signature of Consumer/Parent/ Legal Guardian) (Date)

The above authorizations are valid for one year from the signed date and must be signed by Guest, parent, or Legal Guardian. Please notify us immediately of any changes.



PETER H. O'MEARA  
COMMISSIONER



STATE OF CONNECTICUT  
DEPARTMENT OF DEVELOPMENTAL SERVICES

\_\_\_\_\_ REGION

M. Jodi Reil  
GOVERNOR

KATHERINE du PREE  
DEPUTY COMMISSIONER

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

\_\_\_\_\_

Allergies: \_\_\_\_\_

\_\_\_\_\_

Epi-Pen needed: Yes  No

Sunscreen Allergy: Yes  No

Diet: Regular Yes  No

Special Modifications/ Restrictions: \_\_\_\_\_

- Consistency:  Whole (able to chew and swallow all forms of food without difficulty)  
 (Please  Cut-up (pieces of food 1/2" x 1/2" x 1/2" roughly the size of a dime x 1/4" high)  
 Check  Chopped (pea-sized, 1/4" x 1/4" x 1/4")  
 One)  Ground (ground in a machine to size of small curd cottage cheese)  
 Pureed (machine blended to a smooth consistency w/a pudding-like appearance)

Liquid Consistency:  Thin (Regular)  Nectar  Honey  Pudding

Last Tetanus Vaccine: \_\_\_\_/\_\_\_\_/\_\_\_\_

Medical Limitations: \_\_\_\_\_

Transfer Instructions: \_\_\_\_\_

Order for Adaptive Equipment/OT/PT/other special Instructions i.e: (blood pressure, blood sugars, etc.)

Check: Helmut  AFO  Wheelchair  Ear Plugs  Side Rails  Other

The orders on this page are in effect for one year from the date signed unless changes have occurred.

Physician: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
Print Name

Address: \_\_\_\_\_ Fax number: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Mail or fax form to: \_\_\_\_\_  
Tel: \_\_\_\_\_ or Fax: \_\_\_\_\_



**STATE OF CONNECTICUT**  
DEPARTMENT OF DEVELOPMENTAL SERVICES

**DDS**  
PETER H. O'MEARA  
COMMISSIONER

\_\_\_\_\_ REGION

**DDS Respite Center  
Physician's Orders**

**Name:** \_\_\_\_\_ **Phone Number:** \_\_\_\_\_  
**Address:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_  
**Diagnosis:** \_\_\_\_\_  
**Allergies:** \_\_\_\_\_

The above patient's family has requested respite services at DDS's respite center. The Connecticut State Laws and Regulations require a physician's written order for a nurse or non-licensed certified staff to administer any routine and/or over the counter medications. Please write out Physician's orders for: medications, diet changes, blood pressure and any other screenings, nebulizers, oxygen and treatments, etc. For all tube feedings, please include type and rate of infusion, pump or bolus, amount, type and times of flush.

Medication (Please print)	Dose	Route	Adm. Time	Reason Given

**The above orders are in effect for 180 days unless otherwise specified. Behavior modifying Medications need to be renewed every 90 days. The RN may adjust medication times as needed.**

Physician: \_\_\_\_\_ **Phone:** \_\_\_\_\_  
 Print name  
 Address: \_\_\_\_\_ **Fax number:** \_\_\_\_\_  
 Physician's signature: \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Mail or fax form to:** \_\_\_\_\_  
**Tel:** \_\_\_\_\_ **or Fax:** \_\_\_\_\_

Name: \_\_\_\_\_  
DDS#: \_\_\_\_\_

DDS RESPITE CENTER PACKET  
\_\_\_\_\_ REGION

**RESPITE CENTER GUEST PERMISSIONS FORM**  
(Completed by Guest/family Member/Guardian prior to visit)

**ALL authorizations are in effect for one year from the date of signature. Please notify us immediately of any changes.**

**1. AUTHORIZATION TO PARTICIPATE IN COMMUNITY ACTIVITIES**

I do  do not  give permission for \_\_\_\_\_ to participate in community activities with the Respite Center Program.  
**First and last name**

**2. AUTHORIZATION FOR PHOTOGRAPHS AND PRESS**

I do  do not  give permission for \_\_\_\_\_ to be photographed for DDS use.

I do  do not  give permission for \_\_\_\_\_ to be photographed for media use.

I do  do not  give permission for \_\_\_\_\_ to appear in media print.

**3. AUTHORIZATION FOR AQUATIC ACTIVITIES**

I do  do not  give permission for \_\_\_\_\_ to participate in boating and fishing activities.

I do  do not  give permission for \_\_\_\_\_ to participate in activities proximal to water\*.

I do  do not  give permission for \_\_\_\_\_ to participate in swimming activities.

\_\_\_\_\_  
(Signature of Guest/Parent/Legal Guardian)

\_\_\_\_\_  
(Date)

For boating, fishing, ice skating, water parks or activities proximal to water, as approved, the following are safe supervision levels for \_\_\_\_\_:  
**First and last name**

<b>Supervision levels:</b>	<b>For boating/fishing</b>	_____ staff for _____ guest(s)	(not approved <input type="checkbox"/> )
	<b>Proximal to water*</b>	_____ staff for _____ guest(s)	(not approved <input type="checkbox"/> )
	<b>Ice skating</b>	_____ staff for _____ guest(s)	(not approved <input type="checkbox"/> )
	<b>Water parks</b>	_____ staff for _____ guest(s)	(not approved <input type="checkbox"/> )

\_\_\_\_\_  
(Signature of Guest/Parent/Legal Guardian)

\_\_\_\_\_  
(Date)

\*Proximal to water = picnics near water, feeding ducks, walks on the beach, etc....  
\*\* Hot tubs cannot be used without a physician's order.

- |  |   |
|--|---|
| <input type="checkbox"/> needs a lifejacket on at all times      | <input type="checkbox"/> independent swimmer trained in safe swim practices   |
| <input type="checkbox"/> can stay in shallow water only          | <input type="checkbox"/> can swim independently without flotation devices     |
| <input type="checkbox"/> no swimming skills                      | <input type="checkbox"/> requires one-to-one guest to staff ratio in water    |
| <input type="checkbox"/> limited swimming skills                 | <input type="checkbox"/> supervision needs will need to be evaluated by staff |
| <input type="checkbox"/> can swim in deep water with supervision | <input type="checkbox"/> other: _____   |

Safe supervision level for swimming for \_\_\_\_\_ is \_\_\_\_\_ staff \_\_\_\_\_ guest(s).  
**First and last name**

\_\_\_\_\_  
(Signature of Guest/Parent/Legal Guardian)

\_\_\_\_\_  
(Date)

Name: \_\_\_\_\_

DDS#: \_\_\_\_\_

**DDS RESPITE CENTER PACKET**  
**Select Region REGION**

**LEISURE INTEREST SURVEY**  
**(Completed by CM/SC or SMRW)**

Name: \_\_\_\_\_

Date: \_\_\_\_\_

D.O.B: \_\_\_\_\_

Address: \_\_\_\_\_

Sex (check box): M  F

Phone: \_\_\_\_\_

DDS Case Manager: \_\_\_\_\_

1. List recreational activities which you currently participate in: \_\_\_\_\_

2. Indicate the recreational activities you prefer to participate in (check all that apply):

- |   |  |  |                                    |
|---|--|--|------------------------------------|
| <input type="checkbox"/> Music/Concerts | <input type="checkbox"/> Arts and Crafts Program | <input type="checkbox"/> Social Events   | <input type="checkbox"/> Day trips |
| <input type="checkbox"/> Aquatics       | <input type="checkbox"/> Spectator Sports        | <input type="checkbox"/> Organized Games | <input type="checkbox"/> Dance     |
| <input type="checkbox"/> Exercise       | <input type="checkbox"/> Organized team Sports   | <input type="checkbox"/> Dining Out      |                                    |
| <input type="checkbox"/> Other: _____   |  |  |                                    |

3. Identify short-term goals you would like to have addressed via recreational participation in activities (i.e. increase social involvement, increase physical activity, etc.): \_\_\_\_\_

4. Identify any medical/physical conditions which may affect participation in activities (i.e. asthma, seizure disorder, allergies, etc.): \_\_\_\_\_

5. Identify support/assistance needed to participate in recreational activities (i.e. staff assistance, adaptive equipment, etc.): \_\_\_\_\_

6. Identify issues, or concerns regarding community integration (i.e. fear of animals, transportation, limited attention span, Decreased safety awareness, loud noises, large groups, etc.): \_\_\_\_\_

7. Are you satisfied with your current level of participation in recreation and school activities?

Yes  No Explain: \_\_\_\_\_

8. Do you have money to pay for recreational activities?

Yes  No

9. Would you like to learn about Self-Advocacy?

Yes  No

Name: \_\_\_\_\_  
DDS#: \_\_\_\_\_

**LEISURE INTERESTS**

Check the activities that best describe your leisure interests. If you dislike or are not interested in an activity, Leave the space blank.

**Music**

- Listening to music
- Playing instruments
- Attending concerts
- Singing
- Other (specify): \_\_\_\_\_

**Arts & Crafts**

- Candlemaking
- Painting
- Woodworking
- Drawing
- Basketweaving
- Ceramics
- Latch hook
- Stenciling
- Other (specify): \_\_\_\_\_

**Hobbies/Interests**

- Attending church/temple
- Gardening/horticulture
- Cooking/baking
- Travel
- Photography
- Puzzles
- Shopping
- Computers
- Other (specify): \_\_\_\_\_

**Social Activities**

- Social Group
- Parties
- Dances
- Barbecues/picnics
- Fairs/festivals
- Parades
- Amusement Parks
- Dining out
- Other (specify): \_\_\_\_\_

**Sports and Exercise**

- Camping
- Dancing
- Aerobics
- Horseback riding
- Swimming
- Softball
- Basketball
- Bowling
- Soccer
- Tennis
- Jogging
- Miniature golf
- Hiking
- Fishing
- Bike riding
- Boating/canoeing
- Kite flying
- Sledding/tobogganing
- Roller/ice skating
- Frisbee
- Other (specify): \_\_\_\_\_

**Entertainment**

- Movies
- Plays
- Sporting events
- Museums
- Nature centers
- Arcades
- Other (specify): \_\_\_\_\_

**Games**

- Billiards
- Cards/Uno
- Checkers
- Bingo
- Table tennis
- Other (specify): \_\_\_\_\_

Name: \_\_\_\_\_  
 DDS#: \_\_\_\_\_

**DDS RESPITE CENTER PACKET**  
 \_\_\_\_\_ **REGION**  
**EVALUATION FOR BATHING AND PERSONAL CARE SAFETY SUPERVISION**

Date Evaluation Completed: \_\_\_\_\_

Name: \_\_\_\_\_

DOB: \_\_\_\_\_

MR Level: \_\_\_\_\_

Guest Uses:     Bathtub             Shower             Whirlpool             Other: \_\_\_\_\_

Guest is at risk due to the following medical condition(s), physical disability and/ or behavioral issue(s):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**SUPERVISION**

- No supervision required. Guest can bathe independently – no medical, physical or behavioral risks.
- Some supervision is required. Explain type of supervision needed and reason: \_\_\_\_\_
- \_\_\_\_\_
- Full, continuous supervision at all times while bathing. Explain type of supervision needed and reason: \_\_\_\_\_
- \_\_\_\_\_

Number of people needed to assist guest with bathing:    0     1     2     3

Please describe need for assistance and / or bathing routine: \_\_\_\_\_

Guest Needs	yes	no	Comments /Specifics
Ambulatory	yes	no	
Can call for assistance	yes	no	
Utilizes adaptive equipment (i.e. safety straps)	yes	no	
Complies with adaptive equipment	yes	no	
Uses special shampoo	yes	no	
Allergic to soaps	yes	no	
Uses lotions	yes	no	
Uses ear plugs	yes	no	
Enjoys bathing	yes	no	

Enter a prompt in the right hand column for each task using the key below

PROMPT LEVELS	TASK	PROMPT
<b>I</b> = Independent	Turns water on and off	
<b>V</b> = Verbal Prompt	Regulates water temperature	
<b>P</b> = Physical Prompt	Gets in and out of tub or shower	
<b>M</b> = Physical Manipulation	Washes Body	
<b>U</b> = Physically or cognitively unable to do	Shampoos hair	
<b>R</b> = Refuses to do	Dries body	

Information provided by: \_\_\_\_\_

Date: \_\_\_\_\_

Signature of Person completing form: \_\_\_\_\_

Date: \_\_\_\_\_

Name: \_\_\_\_\_  
 DDS#: \_\_\_\_\_

Attachment H

**DDS RESPITE CENTER  
 \_\_\_\_\_ REGION  
 PRE-ADMISSION HEALTH CHECKLIST  
 (Completed by Nursing Staff, SMRW)**

<b>Guest Name:</b> _____		<b>Address/Town:</b> _____	
<b>Contact Person:</b> _____		<b>Relation:</b> _____	
		<b>Home Phone:</b> ( ) - _____	
<b>Dates Approved For Respite:</b> from _____ / _____ / _____		<b>AM/PM to</b> _____ / _____ / _____ <b>AM/PM</b>	
<b>Seizure Disorder:</b> No <input type="checkbox"/> Yes <input type="checkbox"/>		<b>If yes, type:</b> _____ <b>frequency:</b> _____	
		<b>Duration:</b> _____ <b>Date of last seizure:</b> _____	
<b>Recent Illnesses/Injuries/Hospitalizations within the past year:</b> _____			
<b>Date Last Menses:</b> _____ / _____ / _____		<b>Comments:</b> _____	
<b>Concerns Discussed:</b> _____			
<b>Medic Alert Bracelet: (Type/Reason):</b> _____			
<b>Allergies/Reactions (medications, food, seasonal, other):</b> _____			
<b>Medications:</b> Routine <input type="checkbox"/> PRN <input type="checkbox"/> None <input type="checkbox"/> <b>Requested to bring in medication:</b> Yes <input type="checkbox"/> No <input type="checkbox"/>			
<b>How is medication administered?</b> _____			
<b>Is there a constipation problem?</b> Yes <input type="checkbox"/> No <input type="checkbox"/>			
<b>If yes, please describe interventions:</b> _____			
<b>Medical/Adaptive equipment used?</b> Yes <input type="checkbox"/> No <input type="checkbox"/> <b>Requested to bring in?</b> Yes <input type="checkbox"/> No <input type="checkbox"/>			
<b>If used, list all equipment:</b> _____			
<b>If summer, requested to bring in sunscreen?</b> Yes <input type="checkbox"/> No <input type="checkbox"/>			
<b>Dietary Supplement required:</b> Yes <input type="checkbox"/> No <input type="checkbox"/>		<b>If yes, type:</b> _____	
		<b>Requested to bring in?</b> _____	
<b>G-Tube:</b> Yes <input type="checkbox"/> No <input type="checkbox"/> <b>Type:</b> _____		<b>J-Tube:</b> Yes <input type="checkbox"/> No <input type="checkbox"/> <b>Type:</b> _____	
		<b>Type of infusion Pump:</b> _____	
<b>Type of Feeding:</b> _____		<b>Requested to bring in?</b> _____	
<b>Dietary restrictions:</b> _____			
<b>Is there a swallowing problem?</b> Yes <input type="checkbox"/> No <input type="checkbox"/> <b>If yes, please explain:</b> _____			
<b>Physician's Orders up-to-date?</b> Yes <input type="checkbox"/> No <input type="checkbox"/>		<b>DATE EXPIRED</b> ____/____/____	<b>Comments:</b>
<b>Authorizations up-to-date:</b> Yes <input type="checkbox"/> No <input type="checkbox"/>		<b>DATE EXPIRED</b> ____/____/____	<b>Comments:</b>

Information was obtained via telephone on: DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_ at \_\_\_\_\_ AM / PM

Signature of individual completing form: \_\_\_\_\_







OPTIONAL INFORMATION

Name: \_\_\_\_\_

DDS#: \_\_\_\_\_

Attachment L

DDS RESPITE CENTER  
\_\_\_\_\_ REGION

**GUEST SURVEY**  
(Completed by SMRW or Designee)

It is our hope that you enjoyed your experience with \_\_\_\_\_ Family Respite Center. The respite center Staff are dedicated to providing quality support, a comfortable environment, and fun for your family member during their respite stay. The following questions have been developed to help us better understand the needs and concerns of our visitors and families. Thank you in advance for taking the time to complete the questionnaire.

**Questions for the individual/visitor**

- 1. When you found out that you were coming to visit the center, were you looking forward to your visit? Yes  No
- 2. Did you feel comfortable with the staff? Yes  No
- 3. Did you feel comfortable with other visitors? Yes  No
- 4. Did you enjoy the food? Yes  No
- 5. Did you enjoy the activities?  
Explain: Yes  No
- 6. Did you like the room you slept in?  
Explain: Yes  No
- 7. Would you like to visit the center again? Yes  No
- 8. What would make your stay better?

Additional comments/suggestions (use back if necessary): \_\_\_\_\_

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Name: \_\_\_\_\_  
 DDS#: \_\_\_\_\_

DDS RESPITE CENTER  
 \_\_\_\_\_ REGION

**RESPITE EVALUATION**  
 (Completed by SMRW or Designee)

Name:		D.O.B:
Case Manager/ Service Coordinator:		Center Location:
Date of Arrival:	Time of Arrival:	
Date of Departure:	Time of Departure:	

**Abilities and Skills**

**Describe the Skill Level and the Amount of Assistance Required**

Eating/Drinking: Self  With Assistance  Total Care  Equipment Needed

Dressing: Self  With Assistance  Total Care  Equipment Needed

Toileting: Self  With Assistance  Total Care  Equipment Needed

Bathing: Self  With Assistance  Total Care  Equipment Needed

Grooming: Self  With Assistance  Total Care  Equipment Needed

Communication: Verbal  Non-Verbal  Sign  Language Board/Communication Device   
 Hearing Impairment  Hearing Aid  Language Spoken:

Mobility: Independent  Walker  Wheelchair  Other:

Visual Impairment: Glasses  Blind  None

Sleeping Patterns: \_\_\_\_\_  
 \_\_\_\_\_

Social Interactions: \_\_\_\_\_  
 \_\_\_\_\_

Staff/Guest Interaction: \_\_\_\_\_  
 \_\_\_\_\_

Guest Comments: \_\_\_\_\_  
 \_\_\_\_\_

Behaviors Observed: \_\_\_\_\_  
 \_\_\_\_\_

Comments: \_\_\_\_\_  
 \_\_\_\_\_

Suggestions for Future Respite: \_\_\_\_\_  
 \_\_\_\_\_

Completed By: \_\_\_\_\_ Date: \_\_\_\_\_  
 (SMRW/Designee)

Reviewed By: \_\_\_\_\_ Date: \_\_\_\_\_  
 (FS Respite Coordinator)

Reviewed By: \_\_\_\_\_ Date: \_\_\_\_\_  
 (Supervisor)

Name: \_\_\_\_\_  
 DDS#: \_\_\_\_\_

**DDS RESPITE CENTER PERSONAL ITEMS INVENTORY**  
 (Completed by SMRW or Designee. Copy kept in Respite File)

<b>Individual:</b>	<b>Admitting Staff:</b>	<b>Date:</b>
<b>Date In:</b>	<b>Parent Signature(Ad.):</b>	<b>Date:</b>
<b>Specify number:</b> Suit Cases <input type="checkbox"/> Gym Bags <input type="checkbox"/> Back Packs <input type="checkbox"/>	<b>Discharge Staff:</b>	<b>Date:</b>
Grooming Bag <input type="checkbox"/> Handbag <input type="checkbox"/> Wallet <input type="checkbox"/>	<b>Parent Signature(Dis.):</b>	<b>Date:</b>
<b>Other:</b>		<b>Date:</b>

**Underwear**

Quantity	In	Out
Underpants		
Undershirts		
Bras		
Socks		
Stockings		
Tights		
Diapers		
Attends		
Rubber pants		
Slips		

**Enjoyment**

Quantity	In	Out
Radio		
Cassette Player		
Tapes		
Videos		
Sec. Blanket		
Pillow		
Books		
Camera		
Toys		

**Outerwear**

Quantity	In	Out
Coat		
Jacket		
Hat		
Gloves		
Scarf		
Rain Gear		

**Tops**

Quantity	In	Out
Blouses		
Dresses		
Tank Tops		
T-Shirts		
Long sleeve		
Short sleeve		
Sweaters		
Sweatshirts		

**Miscellaneous**

Quantity	In	Out
Make up		
Pads		
Tampons		
Jewelry		

**Bottoms**

Quantity	In	Out
Shorts		
Skirts		
Jeans		
Cords		
Slacks		
One-piece outfits		
Bathing Suit		
Sweat Pants		

**Footwear**

Quantity	In	Out
Shoes		
Sandals		
Sneakers		
Boots		

**Grooming**

Quantity	In	Out
Comb		
Brush		
Pick		
Hair Accessories		
Shampoo		
Conditioner		
Tooth Brush		
Tooth Paste		
Shaving Cream		
Razor		
Electric Razor		
Lotions		
Powder		
Chap Stick		

**Night Wear**

Quantity	In	Out
Pajamas		
Bathrobe		
Slippers		
Slipper Socks		

**Adaptive Equipment**

	In	Out

**Clothes Worn In**


Name: \_\_\_\_\_  
 DDS#: \_\_\_\_\_

**DDS RESPITE CENTER**  
 \_\_\_\_\_ REGION  
**LEISURE ACTIVITIES**  
 (Completed by SMRW or Designee)

Name: \_\_\_\_\_ Duration of Stay: \_\_\_\_\_

- Preferred activities: 1. \_\_\_\_\_  
 2. \_\_\_\_\_  
 3. \_\_\_\_\_

**COMMUNITY ACTIVITIES**

Date	Activities Offered	Time	Reaction: 1-Dislikes 2-Indifferent 3-Enjoyed	Interacted with Community (check here)	Comments/Observations (i.e. was attentive, enjoyed activity or skill level, explain community interactions)	Staff Initials

Total activities offered: \_\_\_\_\_ Total time engaged in activities: \_\_\_\_\_

**IN-HOUSE ACTIVITIES**

Date	Activities Offered	Time	Reaction: 1-Dislikes 2-Indifferent 3-Enjoyed	Interacted with Community (check here)	Comments/Observations (i.e. was attentive, enjoyed activity or skill level, explain community interactions)	Staff Initials

Total activities offered: \_\_\_\_\_ Total time engaged in activities: \_\_\_\_\_ RTI or Designee Signature: \_\_\_\_\_

DDS RESPITE CENTER  
DDS \_\_\_\_\_ Region  
PICA Prevention Guidelines for Respite Centers

PICA behavior is the ingestion of non-food, inedible objects, including liquids that are not suitable for human consumption. PICA should be distinguished from "mouthing", which is sucking or chewing on objects (fingers, toys, clothing) that cannot be swallowed because of size (definition taken from S.C RPOG 2-M). PICA may be part of a compulsion to eat/drink non-food items or it may be due to the fact that the person cannot distinguish between food and non-food items because their mental age is below three years.

This is a general guideline regarding interventions for PICA at the DDS respite centers. Information regarding supervision interventions and items the individual may ingest needs to be obtained from families/caregivers prior to admission. The environment in each setting needs to be considered, since different environments present a different set of circumstances. All attempts will be made to create a safe, supervised environment. As part of the respite packet, the **PICA Information Form** must be completed.

1. Prior to the individual with PICA entering the respite center, consideration needs to be given to securing cleaning supplies, shampoo, soap, and other items which have the potential to be ingested. Floors need to be vacuumed, swept, and mopped for cleanliness.

2. Clothes, furniture, and other items must be free of loose threads, pieces or other features that may be broken off, or removed and ingested.

3. The environment must be inspected on a regular basis several times per day to ensure there is no access to items the individual may ingest. All staff have a responsibility to routinely inspect the environment. If necessary, the staff person in charge may put into place an environment inspection form.

4. The staff must maintain visual supervision of the individual during awake hours. The staff person in charge may designate another staff member to do this and may rotate the responsibility. Visual supervision is to be provided – this must be clearly communicated to staff.

5. Staff needs to be vigilant in providing supervision when individuals are in vehicles or away from the Respite Center. The vehicle needs to be checked prior to each use for wrappers, rocks, etc. to eliminate the opportunity for the individual to find ingestible items since there is potential for staff to be distracted from the individual(s) with PICA.

6. Prior to bedtime, bedrooms need to be checked for items on the floor, bed, dressers, table, etc. to ensure there are no such items which could be ingested. Please keep in mind how the roommates are assigned. Supervision checks need to be determined by the SMRW, or designer after discussion with the family/caregiver. If an individual attempts to ingest an item, staff need to intervene. Block and secure the item before it is ingested. Do not put your fingers in an individual's mouth to remove the item.

In the event an individual ingests an inedible item, the nurse will be contacted to determine the follow up treatment. In the event of obvious distress or for any chemical ingestion, 911 will be called and the guardian and on-call manager will be contacted.

Name: \_\_\_\_\_  
DDS#: \_\_\_\_\_

**DDS RESPITE CENTER**  
\_\_\_\_\_ **Region**

**PICA Information for Respite Center Visits**

**THIS FORM IS VALID FOR ONE YEAR FROM THE DATE OF SIGNATURE.  
PLEASE NOTIFY US IMMEDIATELY OF ANY CHANGES.**

Name of Individual: \_\_\_\_\_ Date Form Completed: \_\_\_\_\_

1. Items the individual has ingested that are non-food:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. How often does this happen?:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. When was the last time that they ate or drank a non-food item, and what was the item?:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. How do you address this behavior in the home/school program/day program?:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5. Do you have a specific written PICA guideline used at home/ school program/day Program? If yes, please provide a copy:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

6. Please list the level of supervision\* when the individual is:

Awake : \_\_\_\_\_  
Sleeping : \_\_\_\_\_  
In bathroom: \_\_\_\_\_

**\*If family/caregiver stated the individual requires a 24 hour 1:1 within arms length, this situation will need to be reviewed at an administrative level.**

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
**Signature of Legal Guardian/Parent**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Signature of Staff**

\_\_\_\_\_  
**Date**