APPLICATION / ADMISSION INFORMATION PACKAGE

NAME OF PROGRAM**:** _____

Name: _____ **D.O.B.** ____/____/_____ **Gender**: M ☐
Last First day / month / year F ☐

Home Address: _____

_____ **Postal Code:** _____

Telephone #: _____

Family/Caregiver

Name: _____

Address: _____ Postal Code: _____

Telephone #: _____ Cell #: _____

E-mail address: _____

Name of Referring Agency: _____

Medical and Physician Information

Diagnosis: _____

Health Card No. _____ **Version:** _____
Please provide original card, or photocopy

Family Physician: _____ Tel. No: _____

Address: _____

Psychiatrist: _____ Tel. No: _____

Address: _____

Dentist: _____ Tel. No: _____

Address: _____

Other Specialist(s) _____ Tel. No. _____

Address: _____

School: _____ Tel. No. _____

Address: _____

Medications

Is the individual currently taking medications? Yes☐ No☐

If applicable, please attach a list of current medication, doses, etc.

Does the individual self-administer their own medication? Yes☐ No ☐

Medical Treatments Yes☐ No☐

If yes, please specify: _____

_____

_____

Colostomy Care: Yes ☐ No☐

Special Instructions / Comments: _____

_____

_____

Gastric Tube Feeding: Yes ☐ No☐

Special Instructions / Comments: _____

_____

_____

Immunizations

Are the individual's immunizations current? Yes☐ No☐

Please attach a copy of immunization record **(required for the Respite, STATE, Safe Bed programs)**

Drug Allergies Yes ☐ No ☐

If yes, please specify: _____

_____

_____

Food Allergies Yes ☐ No ☐

If yes, please specify: _____

_____

_____

Seizures Yes ☐ No ☐

Description of Seizures – i.e. Type (e.g. Grand Mal, Petit) and Duration

_____

_____

_____

What is the individual's seizure protocol? *(Please provide written instructions)*

_____

_____

_____

_____

_____

Other Medical Considerations:	**Yes**	**No**	**Comments**
Diabetes	☐	☐	_____
Heart Problems	☐	☐	_____
Eating Disorders/Swallowing Problems	☐	☐	_____
Risk of Choking	☐	☐	_____
PICA (eats inedible objects)	☐	☐	_____
Hepatitis B Carrier	☐	☐	_____
Respiratory Problems	☐	☐	_____
History of Head Injury	☐	☐	_____
Kidney Problems	☐	☐	_____
Incontinent - Bladder	☐	☐	_____
- Bowel	☐	☐	_____

ACCESSIBILITY

Vision/Hearing:	**Yes**	**No**	**Comments**
Visual Problems	☐	☐	_____
Wears Corrective Lenses/Contacts	☐	☐	_____
Hearing Problems	☐	☐	_____
Wears a Hearing Aid	☐	☐	_____

Motor Skills	**Yes**	**No**	**Comments**
Sits Independently	☐	☐	_____
Climbs Stairs	☐	☐	_____
Walks	☐	☐	_____
Uses Walker	☐	☐	_____
Uses Wheelchair	☐	☐	_____
Lift/sling	☐	☐	_____
Special equipment required	☐	☐	_____

If deemed necessary, clients that are wheelchair dependent will be transferred using mechanical lifts and slings (for the Respite, STATE, Safe Bed programs)

_____

_____

Communication	**Yes**	**No**	**Comments**
Verbal	☐	☐	
Uses sentences	☐	☐	
Uses words	☐	☐	
Uses sign language	☐	☐	
Understands what is said?	☐	☐	
Languages spoken in the home	☐	☐	
Other languages spoken	☐	☐	
Other languages understood	☐	☐	

Other communications tools (please list):

_____

_____

Behaviour

Does this individual have a current behavioural intervention program? If so, please provide us with a copy.

Aggression Towards Others: Yes ☐ No ☐

Please describe: _____

_____

_____

_____

_____

_____

_____

_____

How are behaviours dealt with? _____

_____

_____

_____

_____

_____

_____

_____

_____

Aggression Towards Self? Yes ☐ No ☐

Please describe: _____

How are behaviours dealt with? _____

Aggression Towards Environment? Yes ☐ No ☐

Please describe: _____

How are behaviours dealt with? _____

Wanders off? Yes ☐ No ☐

Please describe: _____

How are behaviours dealt with? _____

_____

_____

_____

_____

_____

_____

Emotional Profile

	Yes	No		Yes	No
Anxiety	☐	☐	Phobias	☐	☐
Confident	☐	☐	Shy	☐	☐
Happy	☐	☐	Withdrawn	☐	☐
Sociable/Friendly	☐	☐	Poor Self Concept	☐	☐
Obsessive Behaviours	☐	☐	Difficulties		
Attention seeking	☐	☐	with depression	☐	☐

Comments: _____

_____

_____

Religion

Denomination: _____

Specific requests / arrangements: _____

_____

School/Day Program

Attends ☐ Day Programs ☐ School ☐ Work/Workshop

Please Describe (Name, Type, Level of Participation, etc.):

_____

_____

Community Awareness

	Yes	No
Sexually appropriate	☐	☐
Can use public transportation	☐	☐
Understands the concept of money	☐	☐

Family History/Relationships:

With whom/where does the individual currently reside? _____

_____

Parents: _____

_____

_____

Siblings: _____
_____
_____

Grandparents: _____
_____
_____

Is there any history of psychiatric illness in the family? _____
If yes, please describe: _____
_____
_____
_____
_____
_____

Are there any medical conditions in the family?
_____
_____
_____
_____

Additional Information: _____
_____
_____

Mealtime Please list preferred foods: _____
_____

Please list food dislikes: _____
_____

If specific diet is required, please describe:
_____

Specify Food Consistency

Regular: ☐ Chopped: ☐ Minced: ☐ Pureed: ☐

Eating Skills

Independent	☐	Semi-Independent	☐	Dependent	☐
Uses Spoon	☐	Uses Fork	☐	Uses knife	☐
Right handed	☐	Left handed	☐	Drinks from cup	☐
Drinks from straw	☐	Uses regular chair	☐	Sometimes chokes	☐
Hand-over-hand	☐				

Dressing

Independent ☐ Semi-independent ☐ Dependent ☐

Sleeping

Lights on:	Yes	☐	No	☐	Doesn't matter ☐
Sleeps in	Yes	☐	No	☐	Doesn't matter ☐
Sleeps with door open	Yes	☐	No	☐	Doesn't matter ☐
Wakes up at night	Yes	☐	No	☐	Not usually ☐

Sleeps until _____ a.m.

If the individual wakes through the night, what should be done?

_____
_____
_____

Specific Information on the Following

1. Bathing & Showering _____
_____
_____
_____

2. Toileting:

Bladder Function: _____
_____

Bowel Function: _____
_____

3. Dental Care: _____
_____

4. Other Hygiene Considerations/Concerns: _____
_____

DAILY ROUTINES

Usual Routine in the Morning:

_____
_____
_____
_____
_____
_____
_____
_____

Usual Routine in the Afternoon:

Usual Evening and Bedtime Routine:

Strengths the individual has:

Specific Likes & Dislikes of the individual:

Individual Goal Plan

Goals: _____
_____
_____
_____
_____
_____

Goals related to life skills:
_____
_____
_____
_____
_____

Goals related to recreational:
_____
_____
_____
_____
_____

Goals related to behavior:
_____
_____
_____
_____
_____
_____

Other:
_____
_____
_____

Name of the person completing this application: _____

Signature of the person completing this application: _____

Date: _____