Print Form

COMMUNITY LIVING Georgina

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RESPITE SERVICES
CONSUMER INFORMATION FORM
(FOR INDIVIDUALS UNDER THE AGE OF 18)

Intake Date: _____

I **PERSONAL**

Name: _____

Date of Birth: _____

Parent/Guardian: _____

Address: _____

_____

Mailing Address: _____

_____

Telephone: (Res.) _____ (Bus.) _____

Siblings:

Name	**Date of Birth**
_____	_____
_____	_____
_____	_____

Other children/adults in home:

Name	**Date of Birth**
_____	_____
_____	_____
_____	_____

…/2

Educational/Vocational Place: _____

Teacher/Supervisor: _____

Address: _____

Phone #: _____

II **EMERGENCY INFORMATION**

In case of emergency, person to be contacted (other than Parent/Guardian):

Name: _____ Relationship: _____

Address: _____

Telephone Number: _____

III **MEDICAL**

Physician's Name: _____

Telephone Number: _____

Health Card Number: _____

Names of other specialists involved with this client:

_____ _____

_____ _____

_____ _____

Consumer's Medical History:

_____

_____

_____

_____

_____

_____

Consumer's Present Condition:

Special Equipment Required by this Consumer:

Is Medication to be Administered? Yes ☐ No ☐

If "yes" please indicate:

Name of Medication and Purpose	Dosage	Frequency	Time(s) Given	How Administered

Any allergies? Yes ☐ No ☐

If "Yes", please list allergy and reaction:

Does he/she have seizures? Yes ☐ No ☐

If "yes", please describe type, frequency, and duration of a typical seizure. Are there any special precautions?

Please check if applicable:

Physical disability: ☐ Specify: _____

Visual Impairment: ☐ Specify: _____

Hearing Impairment: ☐ Specify: _____

Other: ☐ Specify: _____

IV **ACTIVITIES OF DAILY LIVING**

A) Morning Routine (include waking time, toileting schedule, breakfast/concerns etc.)

_____

_____

_____

_____

_____

B) Bedtime Routine (in order of routine, eg. bath time)

_____

_____

_____

_____

C) Mealtime (please check appropriate one)

☐ Independent ☐ Semi-Independent ☐ Needs total assistance

☐ Holds spoon/fork ☐ Right handed ☐ Left handed

☐ Drinks from cup ☐ Drinks from bottle

☐ Uses high chair ☐ Uses regular chair ☐ Other

Preferred foods (list):

Breakfast: _____

Lunch: _____

Dinner: _____

Dislikes: _____

Additional Comments: _____

_____

_____

_____

D) Brushing Teeth (please check appropriate):

☐ Independent ☐ Semi-Independent ☐ Needs total assistance

Additional Comments: _____

E) Dressing (please check where assistance is needed):

☐ Shirt ☐ Underwear ☐ Snaps

☐ Pants ☐ Bra ☐ Shoelaces

☐ Socks ☐ Dress ☐ Matching Colours

☐ Shoes ☐ Zipper ☐ Belt

☐ Coat ☐ Hat ☐ Gloves

Additional Comments: _____

_____

_____

F) Toileting (please check appropriate choice):

☐ Independent ☐ Semi-Independent ☐ Needs total assistance

How does he/she indicate the need to go?

_____

_____

_____

Does he/she require a special toilet set? Yes ☐ No ☐

If yes, please specify:

_____

_____

If applicable, comment on toileting routine:

_____

_____

_____

G) Sleeping:

Does he/she sleep in: Bed ☐ Crib ☐ Other ☐

Usual bedtime hour: _____

Does he/she wake at night? Yes ☐ No ☐

If so, what should be done?

_____

_____

V **SOCIAL**	Yes	No
Relates well to other children/adults	☐	☐
Afraid of strange places	☐	☐
Difficulties with other children/adults	☐	☐
Shy	☐	☐
Uses public transit	☐	☐
Concept of money	☐	☐
Preferred Activities (ie. TV shows, games, etc.)	☐	☐

Additional Comments: _____

_____

_____

_____

_____

_____

_____

_____

VI **MOTOR**

☐ Sits independent ☐ Stands ☐ Walks ☐ Runs

☐ Climbs Stairs

Comments: _____

VII **RECREATIONAL ACTIVITIES**
(Include participation in clubs, sports, craft, etc.)

VIII **BEHAVIOURAL**

Does he/she have any behavioural difficulties? Yes ☐ No ☐

If yes, please elaborate, indicate method of discipline:

IX **ACTIVITIES TO BE CONTINUED DURING RESPITE**
(Include school, camp, appointments, etc)

X **COMMUNITY AGENCIES INVOLVED**
(Indicate F.R.W., Infant Stimulation Worker, Behavioural Training Worker, etc.)

XI **COMMUNICATION**

☐ Non-verbal ☐ Uses sounds only ☐ Uses words

☐ Uses sign language ☐ Able to follow simple directions ☐ Uses sentences

Comments (include signs): _____

Household Skills (ie. meal preparation, laundry, etc.)

Concept of Money: _____

Supervision required: _____

XII **ADDITIONAL COMMENTS**

Fear of animals? Yes ☐ No ☐

Other fears (storms, sirens, dark, etc): _____

_____ _____

Signature of Guardian Signature of Co-Ordinator

_____

Date

April 2003