

## IDD INDIVIDUAL ASSESSMENT

NAME: \_\_\_\_\_ CASE # \_\_\_\_\_

D.O.B. \_\_\_\_\_ MALE \_\_\_\_\_ FEMALE \_\_\_\_\_

PHYSICAL

ADDRESS: \_\_\_\_\_

\_\_\_\_\_ TEXAS, ZIP CODE \_\_\_\_\_

CONTACT NUMBERS: (HOME) \_\_\_\_\_ (CELL) \_\_\_\_\_

MAILING ADDRESS: (if different) \_\_\_\_\_

RESPONSIBLE PERSON/GUARDIAN \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

EMAIL

ADDRESS: \_\_\_\_\_

(See handbook for encrypted email instructions)

### MEDICAL INFORMATION

Date of last physical \_\_\_\_\_

Allergies: Yes \_\_\_ No \_\_\_ Medications: \_\_\_\_\_

### MEDICATION

Will you need your contract provider to assist in the administration of medication Yes \_\_\_ No \_\_\_\_.  
(if yes, additional medication may be required from family or physician)

If so, I understand that it will be my responsibility to insure all medication information is shared with the Respite / Community Support provider and the provider is kept current of any changes. Medication Administration Training will be required of all contract providers that will monitor or assist in the administration of medication to any individual receiving Respite and/or Community Support services. For weekend Respite services, all medication information pertaining to Dosage, Frequency and Route must be provided by the physician on med sheet prior to date of scheduled Respite.

Are there any other medical/dental/behavioral conditions that the service providers should be aware of?  
(cholesterol or diabetes controlled by diet etc...)

Yes \_\_\_ No \_\_\_ Describe \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Physical Handicaps ? Yes \_\_\_ No \_\_\_ Describe \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Any Prosthetic devices or adaptive equipment ? Yes \_\_\_ No \_\_\_ Describe type and complete instructions for use. \_\_\_\_\_

\_\_\_\_\_

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### SEIZURES/CONVULSIONS

Has the individual ever had seizures or convulsions? Yes \_\_\_ No \_\_\_

Does the individual currently have seizures or convulsions? Yes \_\_\_ No \_\_\_

With medication \_\_\_\_\_ seizures per \_\_\_\_\_

Without medication \_\_\_\_\_ seizures per \_\_\_\_\_

Usual behaviors associated with individual seizure:

\_\_\_ Convulsing      \_\_\_ Chewing/swallowing of tongue      \_\_\_ Loss of consciousness

\_\_\_ Frothing of mouth      \_\_\_ Other \_\_\_\_\_

Describe actions to take during seizure \_\_\_\_\_

Describe individual's behavior after seizure \_\_\_\_\_

### HYGIENE/PERSONAL HABITS

Is individual right handed? \_\_\_\_\_ Left handed? \_\_\_\_\_ Both? \_\_\_\_\_

#### TOILETING:

\_\_\_ Individual can use the toilet with no accidents (day or night) and can go without reminders.

\_\_\_ Bowel Control      \_\_\_ Bladder Control      \_\_\_ Night Accidents

\_\_\_ Needs Assistance      \_\_\_ Needs Reminders      \_\_\_ Wears Diapers

How does the individual indicate the need to use the toilet? \_\_\_\_\_

**BATHING:** Usual time \_\_\_\_\_ (am) or (pm)      Needs Assistance Yes \_\_\_ No \_\_\_

**BRUSHING TEETH:** Usual time \_\_\_\_\_ (am) or (pm)      Needs Assistance Yes \_\_\_ No \_\_\_

#### SLEEP PATTERNS:

Wake Time: \_\_\_\_\_ Bed Time: \_\_\_\_\_ Nap: \_\_\_\_\_

**UNUSUAL SLEEP/BEDTIME HABITS:** (sleep walk, night terrors, stays up late etc...)

*(Keep in mind the person receiving the respite will be required to sleep in his/her own room and will not share a room with any other individuals receiving weekend respite)*

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

Describe actions taken

\_\_\_\_\_

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

### **DRESSING:**

\_\_\_\_ Fully Independent                      \_\_\_\_ Fully Dependent  
\_\_\_\_ Requires Supervision Only            \_\_\_\_ Requires Assistance

### **EATING:**

\_\_\_\_ Eats Independently            \_\_\_\_ Uses Utensils            \_\_\_\_ Requires Assistance  
\_\_\_\_ Other (cutting food into small bits, etc.)

**FOOD ALLERGIES:** Yes \_\_\_ No \_\_\_ Describe \_\_\_\_\_  
\_\_\_\_\_

Foods to Avoid \_\_\_\_\_

Favorite Foods \_\_\_\_\_

Special diet or food preparation required? Yes \_\_\_ No \_\_\_ Describe \_\_\_\_\_  
(family will provide all special dietary foods)

Usual eating times: Breakfast \_\_\_\_\_ Lunch \_\_\_\_\_ Dinner \_\_\_\_\_

Are there any unusual eating habits or concerns. (ie: only eats 2 times a day, takes time eating, eats too fast etc..)  
\_\_\_\_\_  
\_\_\_\_\_

## COMMUNICATION

\_\_\_\_ Blind (fully/partially)                      \_\_\_\_ Deaf (fully/partially)  
\_\_\_\_ Uses easily understood speech            \_\_\_\_ Uses some speech  
\_\_\_\_ Non-Verbal/Verbal                      \_\_\_\_ Understands most speech  
\_\_\_\_ Understands some speech                      \_\_\_\_ Uses other methods of communication.

Additional Information \_\_\_\_\_

## RECREATION

Activities the individual enjoys \_\_\_\_\_

Activities the individual dislikes \_\_\_\_\_

Activities encouraged \_\_\_\_\_

Physical Restrictions? Yes \_\_\_ No \_\_\_ Describe \_\_\_\_\_

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Is there any reason individual receiving respite could not participate in any activity away from the program.

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### BEHAVIOR CHALLENGES

Problematic behaviors that the individual shows \_\_\_\_\_

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Strategies/Reinforcers \_\_\_\_\_

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How does the individual react?

\_\_\_\_ Changes behavior?      \_\_\_\_ Same behavior?      \_\_\_\_ Argues/Threatens?

How do you expect service providers to handle these behaviors? \_\_\_\_\_

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### SOCIAL SUPPORTS

List all Household Members \_\_\_\_\_

Friends \_\_\_\_\_

How does individual respond to family and friends? \_\_\_\_\_

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What behavior in people or things does the individual likes/dislikes? \_\_\_\_\_

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Does the individual have any fears? Yes \_\_\_ No \_\_\_ Describe fear and how you expect provider to handle these fears (animals, loud noises etc..)

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What are the individual's strengths? \_\_\_\_\_

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**TRANSPORTATION**

Please describe any special needs and/or procedures needed \_\_\_\_\_

Please describe individual needs, service requests and other considerations or special information needed, if any.

\*\*\*What trainings might be recommended for staff working with individual? \_\_\_\_\_

\_\_\_\_\_  
INDIVIDUAL/PARENT AND/OR GUARDIAN (Print Name) Date \_\_\_\_\_

\_\_\_\_\_  
INDIVIDUAL/PARENT AND/OR GUARDIAN (Signature) Date \_\_\_\_\_

\_\_\_\_\_  
WITNESS (if applicable-Print/Signature) Date \_\_\_\_\_

**ASSESSMENT COMPLETED and/or REVIEWED BY**

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\_\_\_\_\_  
Signature(Staff)

\_\_\_\_\_  
Date