

II. Client Profile Data:

Clients Full

Name _____

Social Security Number: _____

Date of Birth: _____ State/ County of Birth: _____

Sex: _____ Race: _____ Marital Status: _____

Religion: _____ Language Spoken: _____

Medicaid Number: _____ Medicare Number: _____

Private Insurance Name: _____ Number: _____

Client's Legal Guardian: _____

Address: _____

Telephone Number: _____ Cell: _____

Purpose of Placemet:

Family Information:

A. Father's Full Name: _____

Address: _____

Telephone: _____ Cell: _____

Date of Birth: _____ Age: _____

State/ County of Birth: _____

Father's Social Security Number: _____

Employer's Name _____

Address: _____

Telephone Number: _____

B. Mother's Full Name: _____

Address: _____

Telephone: _____ Cell: _____

Date of Birth: _____ Age: _____

State/ County of Birth: _____

Mother's Social Security Number: _____

Employer's Name _____

Address: _____

Telephone Number: _____

C. Siblings: Give Names and Ages, Address and Telephone

Number: _____

D. Emergency Contacts:

a. Guardian if Applicable: _____

Address: _____

Telephone: _____ Work: _____

b. Name: _____

Address: _____

Telephone: _____ Work: _____

III. Consumer Assessment Data

Name of Physician: _____ Telephone: _____

Address: _____

Indicate Consumer's Level of Functioning

- A. _____ Mild Mental Retardation
- B. _____ Moderate Mental Retardation
- C. _____ Severe Mental Retardation
- D. _____ Profound Mental Retardation

Date of Testing _____ Instrument Used: _____

Results: _____

Indicate Consumer's Adaptive Behavioral Level:

- A. _____ Mild
- B. _____ Moderate
- C. _____ Severe

Date of Testing _____ Instrument Used: _____

Results: _____

Cause of Mental Retardation:

- A. _____ Present at Birth
- B. _____ Head Injury
- C. _____ Related to Illness and Sickness

Comments: _____

Does anyone in the Family other than the consumer have mental retardation? _____yes_____no

Diagnosis:

Axis I: _____

Axis II: _____

Axis III: _____

Axis IV: _____

Axis V: _____

Current GAF: _____ Highest GAF in Past Year: _____

_____ Height

_____ Normal Hearing

_____ Weight

_____ Normal Speech

_____ Glasses

_____ Normal Vision

_____ Wheelchair

_____ Ambulatory

_____ Hearing Aid

_____ Semi Ambulatory

_____ Helmet

_____ Non Ambulatory

Problems with Bowel/ Urinary _____

Food Allergies _____

Drug Allergies _____

Environmental Allergies _____

Positive Hepatitis B Screening _____

Positive TB Skin Test _____

Does Consumer Self Administer Medication _____

List all Physical Impairments _____

Indicate Current Services Consumer receives:

- Nursing Comments _____
- Physical Therapy _____
- Occupational Therapy _____
- Speech Therapy _____
- CAP/MR _____
- ICF/MR _____
- Personal Care Service _____
- Behavior Management _____
- Psychoactive Intervention _____
- Other _____

Behavioral Information

Indicate the Frequency of behaviors with the following codes:

F-Frequent S-Seldom O-Often N-Never

_____ Physical Aggression _____

_____ Verbal Aggression _____

_____ Sexual Misconduct _____

_____ Property Destruction _____

_____ Theft _____

_____ Non Compliance/ Oppositional _____

_____ Self Injurious Behavior _____

_____ Elopement _____

_____ Controlled Substance Abuse _____

Placement History:

Name and Address of Facility	Date of Admission	Date of Discharge	Reason for Discharge

List Consumer's Past and Present Education/Vocation Experience:

Check each one that best describes the consumer. Comment on Strengths/Needs.

Self Help

Comments

- Feeds Independently _____
- Uses All utensils Appropriately _____
- Requires Supervision _____
- Has Physical Impairment Which Prevent/Limit Abilities _____

Comments

- Toilets Independently _____
- Has Toileting Accidents _____
- Incontinent _____
- Has Physical Impairment Which Prevent/Limit Abilities _____

Comments

- Independently Bathes _____
- Requires Staff Supervision and Monitoring _____
- Has Physical Impairment Which Prevent/Limit Abilities _____

Comments

- Dresses Independently _____
- Requires some assistance _____
- Has Physical Impairment Which Prevent/Limit Abilities _____

Comments

- Brushes/ Combs hair _____
- Brushes Teeth/Cares for Dentures _____
- Cares for Menses _____
- Has Physical Impairment Which Prevent/Limit Abilities _____

Decision Making

Comments

- Is Capable of Making Simple Day to Day Decisions _____
- Is Capable of making Major Medical/ Financial/Life Decisions _____
- Requires a moderate amount of assistance _____

Tasks and Home Living Performance

- Performs Simple Household Cleaning Task _____
- Takes care of Laundry/ Clothing Needs _____
- Can Prepare Simple Meals/ Sandwiches _____
- Requires Assistance in Most Areas _____
- Exhibits Cooperation/ Stays on Task _____
- Limitations Due to Physical Impairments _____

Social/ Recreation/ Leisure

- Has Frequent Contact with Family _____
- Gets along well with others _____
- Enjoys most leisure time activities _____
- Independently selects appropriate leisure activities _____

Money Management

Comments

- Requires Assistance _____
 - Independently takes care of money and makes purchases etc. _____
- _____

Health and Safety Orientation

Comments

- Is aware of Environment/ Limitations _____
 - Is realistic about potential despite development disability _____
 - Understands and Senses Danger _____
 - Has a very limited sense of or no sense of danger _____
- _____

Sexual Awareness

Comments

- Does not appear to participate in any type of Sexual Activity _____
 - Demonstrates Appropriate Sexual Activity _____
 - Needs Education/ Training in this area _____
- _____

Communication/ Language

Comments

- Does not communicate verbally but does use other means such as Gestures, Sign Language, Etc. _____
- Initiates Appropriate Conversation Verbally or Through Gestures, Sign Language, Etc. _____
- Understands/Follows Directions Etc. _____

Admissions Committee Review

Date of Review: _____

Summary and

Findings: _____

Disposition: _____ Not Appropriate for ICF/MR

_____ Wait List for ICF/MR

To be completed no more than 31 days prior to admission by a QMRP:

I have examined and assessed _____ and find the consumer to be in need of care, habilitation, training and treatment. It is in my opinion that the consumer would benefit from services provided by NOVA IC.

QMRP _____ Date _____