



ALL ABOUT ME		
My Full Name Is	Please Call Me	Click to add my photo
My Date of Birth Is	Form completed on	
My race	My primary language is	
My sex at birth	Gender I identify as now	

HOW I COMMUNICATE				
To communicate, I use				
Speech Clarity				
Comprehension				
Decision Making				
My pain signs	<input type="checkbox"/> Self-Injury Behavior <input type="checkbox"/> Fetal Position	<input type="checkbox"/> Crying <input type="checkbox"/> Grimacing	<input type="checkbox"/> Flinching <input type="checkbox"/> Screaming	Other
My fear signs	<input type="checkbox"/> Physical Agitation <input type="checkbox"/> Non-responsive <input type="checkbox"/> Still	<input type="checkbox"/> Crying <input type="checkbox"/> Grimacing <input type="checkbox"/> Rapid Breathing	<input type="checkbox"/> Flinching <input type="checkbox"/> Screaming	Other
My anxiety triggers	<input type="checkbox"/> Loud Noises <input type="checkbox"/> Crowds <input type="checkbox"/> Needles <input type="checkbox"/> Separation from favored person	<input type="checkbox"/> Touch <input type="checkbox"/> Men <input type="checkbox"/> Procedures	<input type="checkbox"/> Masks <input type="checkbox"/> Women	Other
My calming techniques	<input type="checkbox"/> Music <input type="checkbox"/> Explain Service <input type="checkbox"/> Favored person	<input type="checkbox"/> Light Touch <input type="checkbox"/> Massage <input type="checkbox"/> Soft Speech	<input type="checkbox"/> Books <input type="checkbox"/> Dim Light	Other

ALL ABOUT ME	
How I react to meeting new people	
What is important/non-negotiable to me	
What makes me comfortable	What makes me uncomfortable
What people appreciate about me	
How to best support me	
I live	

MY BRIEF MEDICAL HISTORY

My risks

- | | | | | |
|--|--|--------------------------------|---|--------------------------------------|
| <input type="checkbox"/> Implants | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Falls | <input type="checkbox"/> Feeding Tube | <input type="checkbox"/> Aspiration |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Pressure injury | <input type="checkbox"/> VNS | <input type="checkbox"/> Shunts | <input type="checkbox"/> Prosthetics |
| <input type="checkbox"/> Joint Replacement | <input type="checkbox"/> NPO (<i>Nothing by mouth</i>) | | <input type="checkbox"/> Cannot bear weight | <input type="checkbox"/> Other |

I am oriented

- to Person (*knows their name*)
- to Place (*knows where they are*)
- to Time (*knows current day/time*)

My vision

My hearing

If I have a DNR, it is on file at

My oxygen usage

My allergies / dietary restrictions

My current medical administration form including diagnosis and allergies is attached

Has a mental health declaration been signed? Yes No

Check all that apply

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Autism | <input type="checkbox"/> Developmental Disability | <input type="checkbox"/> Intellectual Disability | <input type="checkbox"/> Dementia/cognitive decline |
| <input type="checkbox"/> Down Syndrome | <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Liver disease |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Smoker | <input type="checkbox"/> Homeless |
| <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Pregnant | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Age 65 or older |
| <input type="checkbox"/> Corticosteroid use | <input type="checkbox"/> Substance use | <input type="checkbox"/> Cancer | <input type="checkbox"/> COPD |
| <input type="checkbox"/> Immunocompromised | <input type="checkbox"/> Other cognitive/severe communication disorder | | |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Long-term care resident | <input type="checkbox"/> Severe obesity (>40 BMI) | <input type="checkbox"/> Asthma |

My major surgeries and other health concerns

A detailed history of bowel condition, dehydration, sepsis, gastroesophageal reflux disease (GERD), or urinary tract infection (UTI), if applicable

How I use the bathroom

- Incontinent to Bowel
- Incontinent to Bladder
- Urinal
- Commode
- Diapers
- Needs Bathroom Assist
- Raised Commode
- Other

Self-care and mobility

- Handedness
- Dressing
- Bathing
- Oral Care
- Peri-Care
- Hair Care
- Drinking
- Sitting to standing
- Transfers to bed
- Walks ten feet

My diet and nutrition

- | | | | | |
|---------------------------------------|--|--|---|-------------------------------------|
| <input type="checkbox"/> Regular | <input type="checkbox"/> Soft | <input type="checkbox"/> Puree | <input type="checkbox"/> Chopped | <input type="checkbox"/> Mechanical |
| <input type="checkbox"/> Feeding Tube | <input type="checkbox"/> Thickened Liquids | <input type="checkbox"/> History of Aspiration | <input type="checkbox"/> Nothing by Mouth | |

My favorite foods/drinks

How to help me eat

My oral status

- Own teeth
- Dentures
- No teeth
- Missing teeth

How to reposition me (*and BRADEN scale score if known*)

Any other information about me

MY TEAM'S INFORMATION

My legal representative		Phone	Email
My case manager (QIDP)		Phone	Email
A family member	Relationship	Phone	Email
A family member	Relationship	Phone	Email
My Primary Physician		Phone	Email
Organization(s) supporting me		Phone	Email
The support team has assigned the following person to be my primary contact for medical information:			

Prepared with and for me by my Interdisciplinary Support Team.

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