

ASSESSMENT

Social Security Number									
			-			-			

Name														

1. Type of Report (Mark only one):	
<input type="checkbox"/>	1. Initial Assessment
<input type="checkbox"/>	2. Annual Re-evaluation
<input type="checkbox"/>	3. Special Re-evaluation w/HCP Permission
<input type="checkbox"/>	4. Re-admitted From Same Facility
<input type="checkbox"/>	5. Transferred From Another Facility
<input type="checkbox"/>	6. Child Reaching 5 Years of Age
<input type="checkbox"/>	7. Correcting Social Security Number

2. Date Assessment Completed						

3. Medical Conditions - Indicate yes or no for each of the following:		
Y	N	Respiratory
Y	N	Cardiovascular
Y	N	Gastro-intestinal
Y	N	Genito-urinary
Y	N	Neoplastic Disease
Y	N	Neurological Diseases

4a. Does individual have a history of seizures?	
Yes (1)	No (2)

4b. Which type of seizure has the individual experienced in the last twelve months? (Mark all that apply)	
<input type="checkbox"/>	No seizures this year
<input type="checkbox"/>	Simple partial (Simple motor movements affected; no loss of awareness)
<input type="checkbox"/>	Complex partial (Loss of awareness)
<input type="checkbox"/>	Generalized -absence (Petit Mal)
<input type="checkbox"/>	Generalized -tonic-clonic (Grand Mal)
<input type="checkbox"/>	Had some type of seizure-not sure of type

4c. Frequency - In the past year, how frequently has the individual experienced seizures that involve loss of awareness and/or loss of consciousness?	
<input type="checkbox"/>	1. None during past year
<input type="checkbox"/>	2. Less than once a month
<input type="checkbox"/>	3. About once a month
<input type="checkbox"/>	4. About once a week
<input type="checkbox"/>	5. Several times a week
<input type="checkbox"/>	6. Once a day or more

5a. Is Individual currently taking prescription medication?	
Yes (1)	No (2)

5b. Medications - Mark all prescription medications the individual receives		
	Not Currently	Currently
Antipsychotic medication	1	2
Antianxiety medication	1	2
Antidepressant medication	1	2
Anti convulsant medication	1	2
Diabetes medication	1	2
Sedative/hypnotic medication	1	2
Other maintenance medication	1	2

5c. Does Individual receive medication by injection?	
Yes (1)	No (2)

5d. Level of Support - Which best describes the level of support the individual receives when taking prescription medications	
<input type="checkbox"/>	1. No medications
<input type="checkbox"/>	2. Total Support
<input type="checkbox"/>	3. Assistance
<input type="checkbox"/>	4. Supervision
<input type="checkbox"/>	5. Independent

6. Indicate whether or not the individual:		
Y	N	Missed more than a total of two weeks of regular activities due to medical conditions during the last year
Y	N	Was hospitalized for a medical problem in the last year
Y	N	Presently requires care giver be trained in special health care procedures (e.g., ostomy care, positioning, adaptive devices)
Y	N	Presently requires special diet planned by dietitian, nutritionist, nurse, e.g., high fiber, low calories, low sodium, pureed