Abrazos Family Support Services
CHILD AND ADULT RESPITE INFORMATION FORM

Name: _____ DOB: _____ Gender: □Male □Female
Phone: Home: _____ Cell: _____ Work: _____
Address: _____ City: _____ State: _____ Zip: _____
Medicaid #:_____ Medicaid Waiver #: _____
Exempt: □ no □ yes Salud: □no □yes: □ Molina □ Presbyterian □Lovelace □BCBS
Medical Insurance: _____ Policy/Group Numbers: _____
Dental Insurance: _____ Policy/Group Numbers: _____
Guardianship status: _____
Parents/Guardian's Name: _____
Parent/Guardian's Phones Home: _____ Work: _____ Cell: _____ Other: _____
Parent/Guardian's Address: _____
Case Manager: _____ Agency: _____ Phone: _____
Primary Doctor: _____ Day Phone: _____ On Call Phone: _____
Dentist: _____ Day Phone: _____ On Call Phone: _____
Hospital Preference: _____Address _____
Participant's Diagnosis/Disability: _____
Participant's general health: _____ Visual Ability? _____ Hearing Ability?_____
Medical History (heart problems, ear infections, respiratory problems, etc)? _____
_____
Does the participant have any contagious diseases (AIDS, Toxoplasmosis, H Flu, Herpes, CMV, etc?)
_____
Hospitalizations: _____
Seizures: □no □yes Type of Seizure: _____What triggers a seizure: _____
Length of Seizures: _____ How often are seizures? _____ Describe a seizure: _____
What do you want the care-giver do during and after a seizure? _____
Allergies: Food: _____ Environmental: _____
Drug: _____ Other: _____
What should the care-giver do if the participant has an allergic reaction? _____
Special Health Concerns: When should a care-giver call: Doctor _____
911_____
Special Care Instructions for Doctors: _____
Immunization Status: □Current □Incomplete □No Immunizations

Name of Emergency Contacts	Home Phone	Work Phone	Cell Phone	Other
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Does this participant have a Medical Crisis Plan: □no □yes (Please provide a copy)

Please describe the participant and the things a care-giver needs to know in order for respite to go well: _____

_____

_____

_____

_____

_____

Living Situation: List the other people living in the home and their relationship to the individual

Full name	**Relationship**	**DOB**

Directions to individual's home: _____

_____

What are the safety issues for this individual at home? _____

_____

Does the participant have any pets? _____

Family, Friends, and Natural Supports that the participant likes to spend time with? _____

_____

_____

_____

Who may visit during respite? _____

Have there been any recent major life events which have impacted on the participant (divorce, separation, death, move) _____

_____

First and last names of person authorized to pick up this individual thereby ending respite:

_____

_____

CULTURAL BACKGROUND

Participant's cultural and religious background: _____
Cultural or religious practices the participant does or is involved that care-giver should be aware of:

_____

_____

_____

_____

SELF ESTEEM/PERSONAL COMFORT:

What enhances self esteem?
What are important strengths:
To feel comfortable and content, this person likes to:

SLEEPING HABITS/ROUTINES

Naps: □no □yes Nap times: mornings: _____ _____ afternoons_____ _____

How do you know when to put this person down for a nap? _____

Usual bedtime: weekdays: _____ weekends: _____

Usual wake up time: weekdays: _____ weekends: _____

Wakes during night: □no □yes if yes, What should the care-giver do:

Sleeps in: bed _____ crib _____ other, describe: _____

Sleeps with door □open or □closed?Needs night-light? □no □yes

Takes something special to bed? □no □yes If yes, what is it? _____

Is positioning needed for sleeping? □ no □yes What is the procedure for positioning: _____

Unusual nighttime behaviors (nightmares, sleepwalking)? _____

_____

Describe bedtime routine (what time do you begin, bath? bottle? snack? teeth? pjs? stories? prayers?)

_____

_____

Typical Weekly Schedule (school, job, day habilitation program, therapy, special Olympics, church, clubs) Please enter the activity and the times for each regularly scheduled activity.

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Morning							
Afternoon							
Evening							

Please enter the program name (such as the name of the school, or job) the contact person (teacher, job coach, therapist) their address, phone number, etc.

Program	Contact Person	Contact Phone	Activity Location or address	Wants to go	How does the person get there?

Are there things that they are working on in these programs that you work on at home? What are they?

_____

_____

_____

Are there any special concerns regarding daily, evening or weekend routines: _____

_____

_____

PRESCRIPTIVE MEDICATIONS

Abrazos Family Support Services respite providers cannot administer any prescriptive or non-prescriptive medications to respite clients.

Participant is:
- ☐ totally independent in self administering their medication
- ☐ requires minimal assistance with self-medication administration
- ☐ requires constant attention with self administration of medication
- ☐ requires hand-over-hand assistance to self administer medication
- ☐ someone else must administer medication

Please complete the chart below:

Medication	Strength	Amount Given	Number of Times Given Per Day	Times Given	Purpose	Side Effects

What medication issues should a care giver be concerned about: _____

_____

_____

COMMUNICATION SKILLS

Language used at home: □English □Spanish □Sign Language □other _____
Language this person understands: □English □Spanish □Sign Language □other _____
Describe participant's ability to understand and follow directions: _____
_____
_____

How does the participant convey his/her needs or choice: □ verbally tells you what he/she needs
□ points/gestures □ uses sign language □ uses a communication board □ writes
□ communication dictionary □ other _____
KeyVocabulary:_____
_____

This individual space and touch references:_____
_____

Hearing aids: □ no □ yes If yes, strategies for wearing hearing aid: _____
Equipment needed for effective communication:_____
_____

Environment needed for effective communication:_____
_____

Additional Information concerning communication:_____
_____

MOBILITY NEEDS AND ABILITIES

Mobility: □ walks independently □ problems with balance trips and falls
□ crawls or scoots □ walks with assistance, explain:_____
□ totally dependent on wheelchair; □ can □ cannot propel wheelchair on their own
□ does □ does not need assistance to change or shift their position in the wheelchair
□ other:_____
Transfers: □ transfers independently □ needs assistance with transfers_____
Sitting: □ sits unsupported □ needs special chair □ needs support, explain:_____
Standing: □ unsupported □ needs support □ special stander_____
Equipment: □ cane □ walker □ stroller □ braces □ electric wheelchair □ manual wheelchair
□ gate or transfer belt □ lifts □ other:_____
Environmental adaptations: □ ramps □ safety bars □ bath chair □ bath lift □ chair lifts
□ bolsters/wedges □ other:_____
Fine Motor: □ can point to objects □ picks up small objects □ uses both hands □ uses pencil/crayon
Additional Information:_____

PERSONAL HYGIENE SKILLS

Type of Assistance Needed	Full	Hand over Hand	Visual or Verbal Prompting	Let him do it then go over it	Minimal or None	Comments
A. DRESSING						
Puts clothes on: front to front.						
Holds out arms and legs to assist while being dressed.						
Buttons or zips clothing.						
Puts on socks and shoes.						
Makes choices in clothing to be worn. Describe how choices are made?						
B. UNDRESSING						
Takes off shoes/socks.						
Takes off pants/skirt.						
Takes off coat/jacket/sweater/shirt.						
C. PERSONAL HYGIENE						
Washes hands.						
Washes face.						
Combs hair.						
Brushes teeth.						
Prefers ____bathtub or ____shower						
Adjusts water temperature.						
Shampoos hair.						
Dries body.						
Dries hair with __towel or ___blow drier						
Closes door while bathing.						
Shaves (electric or razor?).						
Able to cut fingernails or toenails.						
COMMENTS						

PERSONAL HYGIENE SKILLS (Continued)

Type of Assistance Needed	Full	Visual or Verbal Prompting	Minimal Assistance Needed	Let him do it then go over it	None	Comments
D. TOILETING						
Indicates need to use bathroom. (how)						
Pulls down pants and underwear						
Transfers to the toilet						
Closes door when using toilet.						
Wipes bottom when done.						
Flushes toilet.						
Washes hands after toileting.						
Awakens at night to go to the bathroom.						
Uses public restrooms .						

	Yes	No	Comments
Wears ___underpants ___diapers/Depends			
Wets the bed.			
On toileting schedule.			What is it?
Unusual toileting habits.			What unusual habits?
Problems with constipation.			What do want the care-giver to do?
Problems with diarrhea.			What do you want the care-giver to do?
On special □ bowel □ bladder program			What do you want the care-giver to do?
Needs assistance when menstruating.			What do want the care-giver to do?
How is privacy ensured for bathing, dressing, and toileting?			

ADDITIONAL INFORMATION:

EATING

Eating schedule, (include approximate times and if it is a meal, snack, or a bottle):

Morning: _____ **Afternoon:** _____ **Evening:** _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Where meals are taken (table, special chair, kitchen)_____

Appetite: good _____ poor _____ average _____ **v**aries _____

Favorite foods:_____

Disliked foods:_____

Snacks allowed (when & how often): _____

Snacks not allowed: _____

	YES	NO	COMMENTS
Eats independently.			
Eats finger foods.			
Uses utensils □ spoon □ fork □ knife			Spills?
Uses special □ plate or □ special bowl			
Can serve self.			
Uses □ bottle □ special cup □ straw □ cup			
Body needs to be positioned and supported.			
Head needs to be positioned and supported.			
Assist closing the mouth.			
Provide □verbal or □ tactile prompts for: □ chewing, □eating, □ to eat slowly, □other			How?
While eating, stimulate the □throat or □jaw □other			How?
Does the food need to be modified, i.e. blended, and thickened.			How?
Does food need to be presented in a special way:			How?
Food allergies:			
Special Diet:			
Tube fed only			
Behaviors while eating:			
Describe any problems with chewing, swallowing, choking, aspiration, textures, etc.			
Other Information concerning diet, nutrition and feeding:			

DAILY LIVING SKILLS AND CAPABILITIES

	Expected to do		Minimal or no assistance needed	Visual or verbal prompts needed	Hand over Hand Assistance needed	Comments
	Yes	**No**				
Wears glasses						
Makes bed.						
Puts away clothes.						
Picks out own clothes.						
Cleans and straightens room.						
Picks up toys.						
Puts clothes in hamper.						
Uses washing machine.						
Uses dryer.						
Folds clean clothes.						
Helps with yard work.						
Vacuums.						
Helps with meal preparation.						
Sets table.						
Clears table.						
Washes dishes.						
Dries dishes.						
Uses dishwasher.						
Uses □ stove □ microwave oven						
Uses telephone (emergency calls)						
	Yes	**No**	**Comments**			
Uses pay phone.						
Recognizes danger/safety signs. Traffic lights Exit signs Poison signs						
Crosses street safely.						
Money-changing skills.						
Can tell time (hour/digital)						

LEARNING STYLE

How does this individual learn best?

□ **Auditory,** by getting verbal prompts or verbal instructions:_____

_____

□ **Visually** by seeing, watching, copying, or having a visual schedule:_____

_____

□ **Tactilely:** by getting tactile prompts, doing, hands-on, hand-over-hand assistance: _____

_____

□ **Other:** please describe:_____

_____

Describe the best way for care-givers to give directions, prompts, encouragement: _____

_____

_____

Best incentives/motivation for learning or doing a task: _____

Best times of the day for learning:_____

Learns best when the environment is:_____

INDIVIDUAL LEISURE ACTIVITIES

Specific home or individual activities enjoyed:
Favorite toys:
Favorite music:
Books/games/cards:
Arts & crafts:
TV shows/videos:
Other:
The best way to provide options for leisure activities?
Best way to give assistance (prompting, reminding, directions) during individual leisure time:
Additional Information:

SOCIAL/COMMUNITY/LEISURE INTERACTION

What kind of social and community settings does the participant prefer?
Can the participant handle crowded situations such as a crowded mall or movie theater?

Community Activities	Where	Safety issues to be aware of
Shopping: Malls, Grocery Store, Flea Market, Garage Sales.		
Parks: swings, slides, sand play, hills, swimming pools		
Educational: museum, zoo, library		
Eating out: fast food, formal, ice cream shops.		
Sporting Events: football, basketball, soccer games,		
Recreational: movies, putt-putt, bowling, billiards		
Clubs/Churches: Boy/Girl Scouts, YMCA, Health Clubs, Church, Religion Classes		
Other:		

Interaction style:

- □ Self-motivated. Suggests social activities □ Shares and interacts well with others.
- □ Will interact only in familiar situations. Examples are:_____
- □ Socially interacts in most situations. What situations are uncomfortable? _____
- □ Needs assistance initiating social interaction. Type of assistance needed? _____

How long is attention span in social situations?

If needed, what is the best way to disengage the participant from the social activity:

How does individual let you know that they have had enough of a social situation:

Specific leisure activities **not** allowed:

COMMENTS:

BEHAVIORAL ISSUES AND SUPPORTS

Does this individual have a behavioral support or crisis plan? ___no ___yes (if yes please attach).

Does this individual cause harm to *self* : □ no □yes if yes, describe what happens:
What triggers or influences these behaviors (i.e., health - emotions - environment)?
What can care-giver do to prevent these behaviors? What works? What doesn't?
What do you want the care-giver to do when these behaviors occur?

Does this individual cause harm to others or destroys property: □ no □ yes If yes, please describe what happens:
What triggers these behaviors (i.e., pain, frustration, and need for attention)?
What can the care-giver do to prevent these behaviors? What works? What doesn't?
What do you want care-giver to do when these behaviors occur?

Does this individual bother others: □ no □ yes If yes, please describe what happens:
What triggers or influences these behaviors?
What can the care-giver do to prevent these behaviors? What works? What doesn't?
What should care-giver do when these behaviors occur?

BEHAVIORAL ISSUES AND SUPPORTS (continued)

Does this individual have repetitive behaviors: □ no □ yes If yes, please indicate what these are: □ Pacing □ Grinding teeth □ Rocking □spinning self or objects □ Odd faces/noises □ Attachment to objects □ Hand movements □ Other:
What influences these behaviors (i.e., boredom, stress, frustration, sleepiness)?
Is there anything you want the care-giver to do when these behaviors occur?

Does this individual have inappropriate social behavior: □ no □ yes If yes, please indicate what these behaviors are: □ Talking too loud □ Removing clothing □ Standing too close □ Telling untruths □ Belching □ Taking food without permission □ Swearing □Other:
Do you know what triggers these behaviors?
What do you want the care-giver to do to teach more appropriate behaviors? What works? What doesn't?

Exhibits Stress / Frustration By:	**What do you want care-giver to do if this occurs?**
□ Refusing to listen	
□ Crying	
□ Striking out	
□ Aggressiveness	
□ Self abuse	
□ Temper tantrums	
□ Manipulating others by:	
□ Stealing	
□ Refusing to move	
□ Other	

BEHAVIORAL ISSUES AND SUPPORTS (continued)

Directions/Intervention/Rewards	How should the care-giver do this?
□ Time out	
□ Talk firmly	
□ Redirect activity	
□ Take away favorite toy/activity	
□ Talk/discuss	
□ Direct eye contact	
□ Ignore	
□ Other:	
Rewards for good behavior:	
Comments:	

Does this individual, for his/her age, have appropriate sexual behavior? □ yes □ no
If no, complete the chart below.

Inappropriate sexual behavior	What do you want care-giver to do if this occurs?
□ Hugs or touches others inappropriately	
□ Lift or touches others' clothing	
□ Undresses self in inappropriate places	
□ Masturbates in inappropriate places	
□ Can be easily taken advantage of sexually	
□ Talks about having a baby some day	
□ Is afraid of the opposite sex	
□ Other, describe:	

Because of these inappropriate sexual behaviors what are the primary safety concerns:

_____

_____

_____