INTAKE FOR

COMMUNITY/RESPITE SERVICES

Participant Name:

Age:

Gender:

DOB:

Reason for Referral to Lou Fruitman/Creating Alternatives:

Participant Address:

Participant Phone # (if applicable):

Home:

Mobile:

Family Members/Legal Guardians & Relationship to Participant (please list):

Phone Numbers

Home:

Work: (mother): (father): (sibling):

Mobile: (mother): (father): (sibling):

E-mail Address:

Emergency Contact

Name: Phone Number: Relationship to Participant:

Does the Participant have the capacity to make his/her own decisions? Does he sign his consent and treatmentdocuments?
Name of School: **Grade or Equivalent:**
Languages Spoken/Cultural & Religious Practices:
Allergies:
Current Medications: **Family Doctor:** **Phone#:**
Medical Concerns:
Referring Agency: **Case Manager (if one):**

PARTICIPANT CARE PLAN

Brief Summary of Current Concerns: (please send a copy of previous assessments, behavioural plans, careplans)

PERSONAL CARE TYPE	**NEED/ LEVEL OF SUPPORT**
HYGIENE	**BATH EQUIPMENT**
BATH	**Method** Sponge: Tub: Shower:
SHAVING	
MOUTH CARE	
SKIN CARE	
DRESSING	
ELIMINATION	**INCONTINENCE**
PERICARE	Bladder: Bowel:
TOILETING	Equipment Aids:
MOBILITY	**EQUIPMENT| MOBILITY AIDS:**
WALKING	Cane: Walker:
AMBULATION	Crutches: Wheelchair:
PARTICIPANT SAFETY	Hospital Bed:
TRANSFERS	Independent: x1Assist: x2Assist: Mechanical Lift:

NUTRITION	**MEAL / GROCERIES**
FEEDING	Independent: Parent/Family Meals on Wheels: Other: Aids:
MEAL PREPARATION	
SPECIAL DIET/ ALLERGIES	
COMMUNICATION	
VERBAL	
NONVERBAL (uses pecs, sign other)	
HEARING AIDS	
VISION	
BEHAVIOUR	
Aggression (describe)	

Verbal Aggression (describe)	
Self-Injury (describe)	
Eloping	
Other	
Medication Reminders	

CARE REQUIREMENTS	
SUPPORTS:	Parent: Family: Support staff: None:
HOUSEKEEPING	
LIGHT CLEANING	
LAUNDRY	
CHANGE BEDDING	
ACTIVITIES AND CARE NEEDS	

PARTICIPANT TRANSFER / DEPENDENCY LEVEL

	Independent Unsupervised	Independent Supervised	Minimum Assistance	One Person Pivot	Two Person Side-by-Side	Lifting Devices Two Person	Reposition One Personor Two
TRANSFERS							

DATE AND SIGN WHEN CARE PLAN COMPLETED AND REVIEWED

PRINT STAFF NAME: INITIALS:

SIGNATURE: DATE:

PRINT STAFF NAME: INITIALS:

SIGNATURE: DATE:

Creating Alternatives

General Medical Consent Form

The undersigned, parents/guardian of___hereby consent and authorized thestaff of Creating Alternatives/Reena to act as our authorized agent should it become necessary for our child to require medical care while he or she is in attendance at Creating Alternatives/Lou Fruitman.

You are hereby authorized and directed to accept this authorization as our permission for any member of Creative Alternatives/Reena to use his/her best judgment in obtaining the appropriate medical service for our child in such circumstances.

We acknowledge and understand that any cost which might be incurred over and above the usual health insurance will be our responsibility. We understand that in the event of illness or accident we will be notifiedwithin a reasonable time frame.

Signature of Parent/Guardian:

Date:

Address:

Telephone #:

Mobile #:

Health Card #:

Physician:

Telephone of Physician:

SPECIAL CONSIDERATION

Personal Skills

Does the person need assistance in toileting needs? If 'Yes' what kind?

Does the individual wear diapers?

Would the individual need assistance during menstrual cycle?

Does the individual need assistance with eating/drinking? If 'Yes' describe ?

Does the individual need assistance with dressing/undressing?

Does the individual have orthopaedic concerns? If 'Yes' what type/kind of support is required:

How does the individual communicate?
( ) Verbal
( ) Sign language
( ) Written
( ) Computer board
( ) Non-verbal
( ) Gestures
( ) Other, Specify :

DIETARY RESTRICTIONS

Foods to avoid:

Foodallergies:

Food preferences:

BEHAVIOURAL CONCERNS (ACTIONS, ENVIRONMENT, APPROACHES):

What makes individual angry/upset:

How does individual display anger:

Best way to support individual when upset/frustrated (i.e. speak with them, leave them alone. give space. etc.):

Best way to approach individual:

Does individual have tendency of becoming aggressive. If so, what behaviours are expressed?

( ) pinching
( ) yelling/ shouting
( ) spitting
( ) swearing/ verbal threats
( ) self- harm
( ) hitting
( ) biting
( ) throwing objects
( ) running away
( ) other
SPECIFY:

INDEPENDENT SKILLS

( ) Independent on TTC/BUS
( ) Can travel on the TTC/Bus with supervision
( ) Is not suitable for TTC/Bus
( ) Can travel by Taxi/Uber independently
( ) Is able to learn several TTC Routes
( ) Is able to book Uber rides independently

PEDESTRIAN SKILLS

( ) No pedestrian skills
( ) Can follow traffic signs
( ) Wanders from group
( ) Will not look both ways before crossing
( ) Needs to be held by hand in community
( ) Can access community independent

SPORTS/ACTIVITY INTEREST:

( ) Swimming
( ) Baseball
( ) Zoo
( ) Sporting Event
( ) Movie
Type:
( ) Arcade/video games:

( ) Other:

( )Bowling/Bocce
( ) Wonderland
( ) Water Park
( ) Volleyball
( ) Music
Type:

( ) Basketball
( ) Dancing
( ) Arts & Crafts
( ) Walking
( ) Eating Out
Where:

MEDICAL DIAGNOSIS

Diagnosis:

Is Individual Immunized for Covid 19?

Doses:

1- Date:
2- Date:
3- Date:

Is the individual immunized for Hepatitis B?

Date:

Medication:

Name	Dosage	Administration Time	Reason for Medication

Epilepsy:

Type of Seizures:

How often do they occur?

Sign or warning that seizure is coming?

Rest period required after seizures:

For how long?

Additional helpful information shared by individual or family member at intake:

Additional notes by family: