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IPOP-General Information

Profile Information

Individual Name*: ______________________ Provider/Program Name: ______________________

Create Date*: __________ Entered By*: ______________________ Title: ______________________

Communication Abilities

Adaptive Equipment required for communication? ☐ Yes ☐ No

If yes, explain ______________________

How does the individual communicate wants and needs? ☐ Verbal ☐ Signs ☐ Gestures

Comments ______________________

Health Care Needs

Medication Allergies? ☐ Yes ☐ No

If yes, what ______________________

Food Allergies? ☐ Yes ☐ No

If yes, what ______________________

Environmental Allergies? ☐ Yes ☐ No

If yes, what ______________________

Can the individual explain medical information to medical professionals? ☐ Yes ☐ No

Comments ______________________

Can the individual apply simple first aid or identify their need for first aid? ☐ Yes ☐ No

Comments ______________________

How does the individual respond to pain? ______________________

List Special Health Care Needs. For any Special Health Care Need listed, note how staff should respond

☐ Diabetes ______________________

SIGNATURE..........................**NAME**..........................**DATE**..........................**TIME**..........**am/pm**

Note:- Required fields are marked with an asterisk (*)

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☐ Seizures

☐ High Blood Pressure

☐ Staff to follow plan of Nursing Service/Protocol

☐ Specific Instructions to Staff

☐ Other

List Adaptive Equipment. For each Equipment selected, note how it should be used

☐ Wheelchair

☐ Cane

☐ Walker

☐ Glasses

☐ Hearing aids

☐ Splints

☐ Bedrails

☐ Other

Staffing requirements for medical/dental appointments/hospitalization

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Does the individual have a Do Not Resuscitate (DNR) order? ☐ Yes ☐ No

Medications

Indicate level of self-medication and type of assistance required ______________________

Indicate precautions for food/liquids (alcohol) due to certain medications ______________________

Indicate any special instructions for medication administration (crushed, with food, applesauce)

Any special modified diet? ☐ Yes ☐ No

If yes, what ______________________

Any adaptive equipment needed? ☐ Yes ☐ No

If yes, what ______________________

Type of monitoring and/or assistance needed ☐ One-on-One ☐ Pacing ☐ Therapeutic Intervention ☐ Other

Reason for monitoring and/or assistance ______________________

Individual's ability to plan, choose and prepare small snacks, lunches, meals, etc. that are nutritionally balanced

Dental Care

Ability to complete all aspects of oral hygiene - include level of assistance required and any required equipment

Dental Prosthesis ☐ Dentures ☐ Edentulous ☐ Partials ☐ Other

Comments ______________________

Behavioral Needs

Behavior Management Program/Staff Guidelines? ☐ Yes ☐ No

Comments ______________________

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Targeted Behaviors Addressed ______________________________

Other concerns/behaviors not addressed in a BMP or staff guidelines ______________________________

Other Significant Information

Comments ______________________________

Individual Rights

Is person aware of personal rights and can protect self? ☐ Yes ☐ No

Comments ______________________________

Capable adult status for program planning? ☐ Yes ☐ No

Voting status ☐ Registered ☐ Not Registered

Ability to consent for medical procedures (may include need to be determined on an individual and case by case procedure)

____

Does the individual have a legal guardian? ☐ Yes ☐ No

If yes, who ______________________________

Does the individual have health care proxy? ☐ Yes ☐ No

If yes, who ______________________________

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