Don Guanella Center, Inc.

37 Nichols Street
Chelsea, Massachusetts 02150
617-889-0179 (phone)   617-889-3363 (fax)

Initial Referral

DATE______________   **General Information**

Individual's Name___________________________________D.O.B._______________

Phone #____SS#______________________

Address with Zip____

Language: Verbal___ Non-Verbal___Primary Language: English_____Other________
(please write in primary language spoken)

Mobility Walks independently   Cane   Walker   Crutches
(Please circle)
Needs assistance – please describe ____

Wheelchair (Electric/Manual) 1 or 2 person transfer   Prosthesis _______Brace_________
(please circle)   Type   Type

Guardian_______________________________Relation to Individual________________

Address with Zip if different than above____

Home Ph__________________Work Ph____________________Cell Ph________________

Day Program/Work/School______________________________Ph_________________

Contact Name ____

Will individual be attending program/work/school while at DGC? Yes No

Special Comments/Instructions____

Medical   Height ___________   Weight _____________

Diagnoses/Disabilities____

Seizure disorder? Yes ___ No ___

Please list names of all medications individual is currently taking.

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Don Guanella Center, Inc.

Behavioral Assessment

Date__________________

Individual's Name____

To better prepare the staff at the Don Guanella Center for your family members stay, it is helpful for us to be aware of their various behaviors. Please indicate this individual's significant behaviors on the checklist provided below. Please note any other significant behaviors in the space provided. Thank you!

Behavior	Yes	No
Self-Injurious If yes please describe		
Runs away		
Takes others food/belongings		
Threatens violence		
Verbally abusive		
Tells untruths		
Difficulty following rules		
Demands attention		
Destroys property		
Assaultive toward others		
Withdrawn/lethargic/disinterested		
Unique mannerisms (e.g. twitching, rocking, etc.) Please specify:		
Tears own clothing		
Incontinent-urine		
Incontinent-feces		
Wears incontinence briefs-daytime		
Wears incontinence briefs-nightime		
Sexually inappropriate		
Inappropriate touching of others		
Exaggerates illnesses/sickness		
Wanders off		
Other-Please specify		
Other-Please specify		
Other-Please specify		

Don Guanella Center, Inc.

Skills Inventory

Date__________________

Individual's Name____

Please indicate Individual's level of functioning on each of the ADL skills identified below:

ADL Skill	Independent	Needs Supervision	Needs Physical Assistance	Comments
Eating				
Drinking				
Brushing Teeth				
Bathing				
Dressing/Undressing				
Shaving				
Combing Hair				
Toileting				
Menstruation				
Operating a Phone				
Taking Medications				
Travel in Community				
Preps Simple Drinks (e.g. coffee, tea, cocoa)				
Preps Simple Snacks (e.g. sandwich, cereal)				
Laundry				
Fold, Put Away Clothes				
Makes Bed				
Signs/Writes Name				

Greets Familiar People Yes____ No____
Approaches Stranger Yes____ No____
Shy/Nervous around New People Yes____ No____

Communication:
Uses Some Words____Slurred Speech ____ Hard to Understand ___

How?____Speaks Clearly/Coherently____

Indicates Needs by Pointing____ Signing____

Follows Directions: Simple Directions____ Complex Directions____

For questions/additional information please contact:
Trish Sauer 617-889-0179 or tsauer.dgc@verizon.net