

# Don Guanella Center, Inc.

37 Nichols Street  
Chelsea, Massachusetts 02150

DATE \_\_\_\_\_

## General Information

Individual's Name \_\_\_\_\_ D.O.B. \_\_\_\_\_

Phone # \_\_\_\_\_ SS# \_\_\_\_\_

Address with Zip \_\_\_\_\_

Gender	Race	Age	Height	Weight	Build	Eye Color	Hair Color

Distinguishing Marks, Scars, etc. \_\_\_\_\_

Diagnoses/Disabilities \_\_\_\_\_

Legal Competency Status \_\_\_\_\_

Language/Type of Communication \_\_\_\_\_

Ability to protect self w/o assistance? Yes \_\_\_ No \_\_\_ Responds to search efforts? Yes \_\_\_ No \_\_\_

**Mobility** Independent Needs assistance – please describe \_\_\_\_\_

(Circle please)

Wheelchair Walker Crutches Cane Prosthesis \_\_\_\_\_ Brace \_\_\_\_\_  
Type Type

Physician's

Name \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

Address/Hospital \_\_\_\_\_

Preferred Hospital \_\_\_\_\_ Health Ins. & # \_\_\_\_\_

Guardian \_\_\_\_\_ Relation to Individual \_\_\_\_\_

Address with Zip \_\_\_\_\_

(if different than individual's)

Home Ph \_\_\_\_\_ Work Ph \_\_\_\_\_ Cell Ph \_\_\_\_\_

Emergency contact # 1 \_\_\_\_\_ Relation to Individual \_\_\_\_\_

(Other than Guardian)

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Emergency Contact #2 \_\_\_\_\_ Relationship to Individual \_\_\_\_\_

(Other than Guardian)

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

**General Information**

(continued)

DATE \_\_\_\_\_ Individual's Name \_\_\_\_\_

Source of Support \_\_\_\_\_

Religious Denomination \_\_\_\_\_

Attends Church/Services? Yes \_\_\_ No \_\_\_ Receives Communion? Yes \_\_\_ No \_\_\_

Recent Deaths in the Family:

Name \_\_\_\_\_ Relation to Individual \_\_\_\_\_

Name \_\_\_\_\_ Relation to Individual \_\_\_\_\_

Please describe any recent changes in living situation, move, new household members,  
etc. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Day Program/Work/School \_\_\_\_\_ Phone \_\_\_\_\_  
(Please circle)  
Program Contact \_\_\_\_\_

Address \_\_\_\_\_

Day Program/Work/School Schedule \_\_\_\_\_

Transportation Company \_\_\_\_\_

Phone \_\_\_\_\_ Contact \_\_\_\_\_

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

Will she need a lunch? Yes \_\_\_ No \_\_\_

Special Comments/Instructions \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**\*\*PLEASE ATTACH A RECENT PHOTO...THANK-YOU!\*\***

# Don Guanella Center, Inc.

## Behavioral Assessment

Omit if previously completed as part of Initial Referral Packet

**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-nighttime		
Sexually inappropriate		
Inappropriate touching of others		
Exaggerates illnesses/sickness		
Wanders off		
Other-Please specify		
Other-Please specify		
Other-Please specify		

**Behavioral Assessment Questionnaire**

If individual has significant behavioral issues which are currently being addressed, please fill out the following two-page questionnaire. If not, please write "Not Applicable" and continue with # 6 on page 5 of this packet. Thank –you.

**DATE** \_\_\_\_\_

Individual's Name \_\_\_\_\_

1. Please identify the **2** most significant behaviors from the checklist on the previous page:

Behavior #1 \_\_\_\_\_

Behavior # 2 \_\_\_\_\_

2. How frequently do these behaviors occur (hourly, daily, weekly, one/month, etc.)?

Behavior	Frequency of Occurrence

3. Please identify if there are certain circumstances that provoke these behaviors (e.g. loud noise, physical contact, hungry, tired, etc.):

Behavior	Provoking Circumstances

## Behavioral Assessment Questionnaire

(continued)

Date \_\_\_\_\_

Individual's Name \_\_\_\_\_

4. Please identify any methods of intervention which have proven to be successful in the past (e.g. redirection, verbal praise, time-outs, positive reinforcements such as a favorite food or activity, etc.):

Behavior	Successful Methods of Intervention

5. Please identify any methods of intervention which have proven to be unsuccessful in the past (e.g. time-outs, verbal discouragement, removal of favorite objects/activities, etc.):

Behavior	Unsuccessful Methods of Intervention

6. List any fears client has. (thunder, darkness, animals) \_\_\_\_\_

\_\_\_\_\_

7. Does client have a favorite stuffed animal, blanket or item we should be aware of \_\_\_\_

\_\_\_\_\_

8. Please identify any other information about this individual's behaviors that would be useful to the staff at the Don Guanella Center.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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 (617) 889-0179 / (617) 889-3699 / Fax (617) 889-3363

**Activities of Daily Living: Skill Inventory**  
 Omit if previously completed as part of Initial Referral Packet

**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 \_\_\_

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Date \_\_\_\_\_

Individual's Name \_\_\_\_\_

Please mark and "X" next to the activities listed below that the client enjoys:

Leisure Activities/Interests	"X"	Leisure Activities/Interests	"X"
Arts and Crafts		Knitting	
Baking/Cooking		Movies	
Bingo		Music	
Board Games		Picnics	
Bowling		Reading	
Card Games		Religious Services	
Crochet		Ring Toss	
Crossword Puzzles		Shopping	
Exercise		Shuffleboard	
Field Trips		Sing-a-Longs	
Gardening		Storytelling	
Horseshoes		Television/Videos	
Jigsaw Puzzles		Word Finds	

In addition to those above, please identify other likes and any dislikes Individual may have:

Likes	Dislikes

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**Medical Assessment To be filled out by family**

**Date** \_\_\_\_\_

Individuals's Name \_\_\_\_\_ Age \_\_\_\_\_ Ht. \_\_\_\_\_ Wt. \_\_\_\_\_

Disabilities \_\_\_\_\_

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**Medical Info.** Circle and describe below if necessary: asthma, irritable bowels, shunts, lactose intolerant, diabetes, difficulty swallowing, dentures/bridges, glasses, hearing aids, artificial limbs, hemorrhoids, anemia, cycle cell anemia, arthritis, other. \_\_\_\_\_

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**Drug Allergies** \_\_\_\_\_

What type of allergic reaction? Rash, nausea, vomiting, breathing difficulties, other?  
(Please circle)

**Food Allergies** \_\_\_\_\_

What type of allergic reaction? Rash, nausea, vomiting, breathing difficulties, other?  
(Please circle)

**Environmental Allergies** \_\_\_\_\_

What type of allergic reaction? Rash, nausea, vomiting, breathing difficulties, other?  
(Please circle)

Seizure Disorder? Yes \_\_\_ No \_\_\_ Please describe a typical seizure \_\_\_\_\_

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Have you had to call an ambulance in the last year because of a seizure? Yes No

Frequency of seizures - daily, weekly, monthly, rarely, other \_\_\_\_\_  
(Please circle)

Duration of seizures - less than 1 min., 1-3 mins, more than 3 mins, other \_\_\_\_\_  
(Please circle)

Typical time to recover from seizure \_\_\_\_\_

Precipitating Conditions \_\_\_\_\_

Are seizures more likely before, during or after menstrual cycle? Yes No  
(circle appropriate)

Any other information about seizures that we would find helpful?

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**Authorization to Provide Medical Treatment**

Date \_\_\_\_\_

Individual's Name \_\_\_\_\_ Social Security # \_\_\_\_\_

DOB \_\_\_\_\_ Health Ins. & # \_\_\_\_\_  
Please attach copy of card

Guardian Name \_\_\_\_\_ Phone \_\_\_\_\_

Relation to Individual \_\_\_\_\_

Emergency Contact # 1 \_\_\_\_\_ Phone \_\_\_\_\_  
Other than Guardian

Relation to Individual \_\_\_\_\_

Emergency Contact # 2 \_\_\_\_\_ Phone \_\_\_\_\_  
Other than Guardian

Relation to Individual \_\_\_\_\_

In the event of an emergency involving \_\_\_\_\_, I  
(Individual's Name)

understand that the staff/personnel at the Don Guanella Center will make every attempt to contact me, or the emergency contacts identified above. If we cannot be reached, I hereby give permission for DGC staff/personnel to act on my behalf in the best interest of my daughter/sister/niece/ward, **(circle one)** and to provide the medical treatment necessary and/or contact emergency medical professionals, if necessary.

**Guardian Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**IMPORTANT** Please fill in the following information.

Type of Provider	Name	Address	Phone
Primary Care Physician			
Pharmacist			
Psychiatrist			
Dentist			
(other)			

**DRUG ALLERGIES** \_\_\_\_\_

**Is Individual still menstruating?** Yes No Regular? Yes No

\*If additional space is required, please write on the back of this form. Thank-you!

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**AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION**

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Individual's Name Date of Birth

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Individual's Address City State Zip

I hereby authorize, \_\_\_\_\_ to release to Don Guanella Center any medical records/information in your possession for my daughter/sister/niece/ward (***circle one***). You are also authorized to discuss above named individuals medical conditions and medications with the nurse or administrative staff at Don Guanella Center.

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**Signature of Client/Guardian/Parent**/\*Other (circle one) DATE

This authorization will remain in effect for 1 year. I understand that I may revoke this authorization at any time by providing the Business Office with a written revocation, and that the revocation will be honored except to the extent that this authorization has been acted upon. I also understand that this information may be redisclosed by the recipient if this recipient is not required to follow privacy regulations or statutes. I understand that I am under no obligation to sign this and that the recipients who I am authorizing to use and/or disclose my information to may not condition treatment, payment, enrollment in a health plan or other fees associated with this request.

**\*NOTE: If signing as "Legally Authorized Representative" Please explain.**

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**PHOTOGRAPH WAIVER**

I, \_\_\_\_\_ hereby grant permission to the Don Guanella Center to take pictures of \_\_\_\_\_ for identification purposes- to be put in her chart, medication administration record, and outside her door when she stays at Don Guanella Center.

**DATE:** \_\_\_\_\_

**SIGNED:** \_\_\_\_\_  
Parent, Guardian, Self (*circle one*)

**Don Guanella Center, Inc.**

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**TRANSPORTATION RELEASE**

I, \_\_\_\_\_ understand that staff from the Don Guanella Center will be transporting my daughter/sister/niece/other (**circle one**),

\_\_\_\_\_ on

occasion. Don Guanella Center will verify that the driver is licensed in the state of Massachusetts and will retain a copy of said valid drivers license in the staff members personnel file. At least one staff member going on an outing will hold current certification in both first aid and CPR.

Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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**Statement About Personal Spending Money**

Don Guanella Center, in programming for the persons we serve, plans activities/events such as shopping, bowling, movies, eating out, and in-house parties, etc. Personal spending money is needed for these activities.

Please check below on the appropriate line to indicate how you wish any personal money brought to Don Guanella is to be cared for. We strongly recommend that **large** amounts of money **not** be brought to Don Guanella. (Usually about \$15 - \$20 is more than adequate for a visit of about a week.)

\_\_\_\_\_ receives respite care at Don Guanella Center.  
(please PRINT individuals name)

**Check one**

\_\_\_\_\_ She may care for any and all of her personal spending money independently. I release Don Guanella Center of all responsibility regarding her money.

\_\_\_\_\_ I authorize Don Guanella Center to care for and help her spend any money that she may take to the Center. I understand that the Center will keep an accurate account of all money and expenditures made on her behalf.

Additional Comments:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Guardian Signature

\_\_\_\_\_  
Relationship

**Don Guanella Center, Inc.**

*37 Nichols Street*

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**STATEMENT REGARDING THE BILL OF RIGHTS**

I \_\_\_\_\_ have received a copy of the BILL OF RIGHTS from  
( Name of **individual**- please PRINT)

DON GUANELLA CENTER. I have had these rights explained to me to the best of my  
ability to understand them.

\_\_\_\_\_  
**Signature** or "X" sign if unable to sign

I \_\_\_\_\_, parent/sibling/guardian of the above named individual  
have received a copy of the BILL OF RIGHTS from DON GUANELLA CENTER. I  
have read them and understand them.

\_\_\_\_\_  
**Signature** of parent/sibling/guardian

\_\_\_\_\_  
Date

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**Medication Form**

**{To be completed by physician}**

**DATE** \_\_\_\_\_ **DOB:** \_\_\_\_\_

Individual's Name \_\_\_\_\_ Guardian's Name \_\_\_\_\_

Physician's Name \_\_\_\_\_ Phone \_\_\_\_\_

Please complete the information below regarding the medications, which individual is currently taking\*

Name of Medication	Dose & Route	Reason for use	Specific Times to be Given

Please list the over-the-counter medications, which you prescribe for this client\*:

OTC Medication	Reasons for Use

\*If additional space is required, please write on the back of the form. Thank –you!

**MEDICATION ALLERGIES** \_\_\_\_\_

Manifested how (hives/rash, upset stomach, wheezing, anaphylaxis) \_\_\_\_\_

Medications need to be crushed                      Yes   No

Medications need to be given with food   Yes   No   What kind of food? \_\_\_\_\_

We give permission for the Licensed/Medication Administration Certified staff/personnel at the Don Guanella Center to administer the medications identified above to \_\_\_\_\_ at the specified times.

(Individual's Name)

Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_

Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_

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**STANDING ORDERS FOR OVER THE COUNTER MEDICATIONS**  
**{To be completed by physician}**

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<b>Name</b>	<b>Date of Birth</b>	<b>Social Security #</b>
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<b>Physician Name</b>	<b>Phone Number</b>	<b>License #</b>
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Following is a list of over the counter medications that Don Guanella Center, Inc. will use if necessary. If there are OTHER medications or doses that you prefer, please cross out the particular medication or dose that is NOT to be used and indicate a substitute on this form

Symptom	Medication	Dose	Route	Frequency
<b>Headache</b>	<b>Tylenol</b>	<b>650 mg</b>	<b>PO</b>	<b>every 4 hours</b>

Call MD if no relief after 1 hour or if headache is accompanied by nausea and vomiting, double or blurred vision, dizziness or unstable gait.

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Symptom	Medication	Dose	Route	Frequency
<b>Fever over 99.6</b>	<b>Tylenol</b>	<b>650 mg</b>	<b>PO</b>	<b>every 4 hours</b>

Call MD if Temp over 103 or if fever lasts more than three (3) days or if fever is accompanied by productive cough, chills, seizure activity, personality changes, rash, vision changes.

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Symptom	Medication	Dose	Route	Frequency
<b>Small cut/scrape</b>	<b>Bacitracin Ointment</b>	<b>thin application</b>	<b>Topically</b>	<b>twice a day</b>

Call MD if area becomes red, hard, tender, warm to touch or if there is any drainage or if client develops a fever.

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Symptom	Medication	Dose	Route	Frequency
<b>Congestion</b>	<b>Robitussin</b>	<b>400 mg</b>	<b>PO</b>	<b>every 4 hours with 8 oz water</b>

Call MD if symptoms persist beyond one (1) week or if accompanied by fever over 101, rash or severe headache.

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**(If any of the above CANNOT be given in their generic form, please indicate.)**

We hereby give permission to Licensed/Medication Administration Certified staff at Don Guanella Center, Inc. to administer the medications listed above during the respite stay of the above named individual.

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date  
Intake Packet P-2 – 6/06

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**To Be Completed by Individual's Physician**  
Comparable Immunization record on Physician/Clinic form acceptable

Individual's Name: \_\_\_\_\_

Date: \_\_\_\_\_

HC Provider Signature: \_\_\_\_\_

**To Be Completed by Individual's Physician**  
Comparable Immunization record on Physician/Clinic form acceptable

Individual's Name: \_\_\_\_\_

Date: \_\_\_\_\_

**IMMUNIZATIONS**

Date of last TETANUS _____	<input type="checkbox"/> Unknown	<input type="checkbox"/> Allergic	<input type="checkbox"/> Never
Date of last FLU SHOT _____	<input type="checkbox"/> Unknown	<input type="checkbox"/> Allergic	<input type="checkbox"/> Never
Date of last PNEUMOVAX _____	<input type="checkbox"/> Unknown	<input type="checkbox"/> Allergic	<input type="checkbox"/> Never
Date of HEPATITIS B VACCINE			
Primary Series (3 shots) _____	<input type="checkbox"/> Unknown	<input type="checkbox"/> Allergic	<input type="checkbox"/> Never
Booster _____	<input type="checkbox"/> Unknown		<input type="checkbox"/> Never
Date of MEASLES/MUMPS/RUBELLA _____ (MMR)	<input type="checkbox"/> Unknown	<input type="checkbox"/> Allergic	<input type="checkbox"/> Never

List any other vaccinations and date (e.g., Lyme, Hepatitis A, Varicella, etc.)

\_\_\_\_\_  
\_\_\_\_\_

**TUBERCULOSIS SKIN TEST (PPD):**

Has client ever had a positive skin test for tuberculosis?  Yes  No  Unsure

If yes, was any treatment given?  Yes (describe) \_\_\_\_\_

No

Date of last PPD \_\_\_\_\_

# ANNUAL PHYSICAL EXAMINATION FORM

Massachusetts Department of Mental Retardation

<b>Name:</b>						<b>Date:</b>		
<b>Vital Signs:</b>	Ht	Wt	T°	BP	P	R		
<b>General Appearance:</b>								
<b>Skin:</b>								
<b>HEENT:</b>								
Head								
Eyes/Vision Screen								
Ears/Hearing Screen								
Mouth/Throat								
<b>Neck:</b>								
<b>Chest:</b>								
<b>Breast:</b>								
<b>Heart:</b>								
<b>Lungs:</b>								
<b>Abdomen:</b>								
<b>Genitalia:</b>								
GYN/Testicular Exam								
<b>Rectum:</b>								
<b>Musculoskeletal:</b>								
Back/Spine								
Extremities								
<b>Lymph Nodes:</b>								
<b>Circulatory:</b>								
<b>Neurologic:</b>								
Cranial Nerves								
Reflexes								
Sensory								
Motor								
Cognitive								
<b>Other:</b>								

HC Provider Signature: \_\_\_\_\_