

NYS OPWDD Nutrition Assessment Form

Name:	DOB:	Age:	Date:
Residence:	Gender:	TAB ID#:	

Food & Nutrition Related History

Route of Nutrition: <input type="checkbox"/> P.O. <input type="checkbox"/> Enteral
Diet Order:
Food Consistency:
Liquid Consistency: select from list
Nutritional Supplements:
Diet Provides Estimated: Calories
Other:
Food Allergies / Intolerances / Restrictions:
Mealtime Behavior:
Mealtime Strengths & Needs:
Dining Ability: <input type="checkbox"/> Independent <input type="checkbox"/> Needs Assistance <input type="checkbox"/> Total Dependence Other:
Adaptive Equipment:
Mobility: select from list Activity Level: select from list
Comments:
Current Medications:
Pertinent Food - Medication Interactions:

Anthropometric Measurements

Height:	Current Weight:	HWR:		
BMI:	<input type="checkbox"/> Underweight <input type="checkbox"/> Normal <input type="checkbox"/> Overweight <input type="checkbox"/> Obese			
Weight History Over Past 12 mos.	Wt. 3 mos. Ago Date:	Wt. 6 mos. Ago Date:	Wt. 9 mos. Ago Date:	Wt. 12 mos. Ago Date:
Comments:				

Biochemical Data

Date	Lab Test Name	Reference Range	Results	Date	Lab Test Name	Reference Range	Results
	Na				Total Chol		
	K				HDL		
	Ca				LDL		
	Glu				TG		
	Alb				Vit D		
	TSH						
	BUN						
	Creat						
	Hgb						
	Hct						
	Hgb A1C						

Nutritionally significant diagnostic tests / procedures:

NYS OPWDD Nutrition Assessment Form

Name:	DOB:	Age:	Date:
Residence:	Gender:	TAB ID#:	

Nutrition-Focused Physical Findings

Oral Condition: select from list

Comments:

Skin Condition: Intact Impaired Comments:

Intake Solids: select from list Comments:

Intake Fluids: select from list Comments:

Bowel Regularity: Maintain with Diet Maintained with Diet and Medication

Comments:

Vision: select from list

Hearing: select from list

Client History

Medical Diagnosis:

Other Client History:

Comparative Standards

Estimated Daily Nutritional Needs:	Calories	g Protein	mL Fluid
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Comments:

Summary:

Nutrition Diagnosis (PES Statement)

Problem #1: select from list

Other:

Related to:

As Evidenced by:

Problem #2: select from list

Other:

Related to:

As Evidenced by:

Problem #3: select from list

Other:

Related to:

As Evidenced by:

Nutrition Intervention

Nutrition Prescription:

Intervention #1:

Intervention #2:

Intervention #3:

Intervention #4:

Intervention #5:

NYS OPWDD Nutrition Assessment Form

Name:	DOB:	Age:	Date:
Residence:	Gender:	TAB ID#:	

Intervention #6:
Individual Goals:

Nutrition Monitoring and Evaluation Plan
#1:
#2:
#3:
#4:
#5:
#6:

Completed by: Name, Credentials	Date:
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Name:	Clinician:
Residence:	DOB:

Name: Nutrition

Outcome Statement: Maintain Good Nutritional Status

Date:

Medical Diagnosis:

Diet:

Intake:

Weight:

Current Weight: BMI: Height:

Healthy Weight Range:

Weight Changes:

Labs:

	Chol	Trig	HDL	LDL	Na	K	Ca	BUN	Creat	Hgb	HCT	MCV	TSH	Glucose	Alb
Normal	<200	<150	>59	<100	135-145	3.5-5.5	8.4-10.8	7-24	0.7-1.5	13.4-17	39.1-49.5	80.0-100.0	0.40-4.50	70-110	>3.5

Lab Comments:

Medications:

Nutrient Drug Interactions:

Bowels:

Comments:

Recommendations:

Signature: _____ **Date:** _____

COMPREHENSIVE FUNCTIONAL ASSESSMENT
EVALUATION
SUMMARY

BDS-MED 608 (9/10)

Individual Name:

C#

QMRP:

Date:

Overview

I. Physical Development:

Strengths:

Needs:

Recommendations:

II. Nutritional:

Strengths:

Needs:

Recommendations:

III. Sensorimotor Development:

Strengths:

Needs:

Recommendations:

IV. Affective Development:

Strengths:

Needs:

Recommendations:

V. Speech and Language Development:

Strengths:

Needs:

Recommendations:

VI. Auditory Functioning:

Strengths:

Needs:

Recommendations:

COMPREHENSIVE FUNCTIONAL ASSESSMENT
EVALUATION
SUMMARY

BDS-MED 608 (9/10)

Individual Name:
QMRP:

C#
Date:

VII. Cognitive:

Strengths:

Needs:

Recommendations:

VIII. Social Development:

Strengths:

Needs:

Recommendations:

IX. Adaptive Living skills:

Strengths:

Needs:

Recommendations:

X. Vocational:

Strengths:

Needs:

Recommendations:

COMPREHENSIVE FUNCTIONAL ASSESSMENT
EVALUATION
NURSING/MEDICAL

BRM-MED 615 (6/10)

Name:

C#:

Date of Evaluation:

Overview:**Developmental History****Consents**

Name:

Address:

Telephone:

I. Physical Development:**Past Illnesses/Medical Diagnosis**

Results/Findings of Physical Exam

Date of Physical Exam:

Findings of Physical Exam:

Allergies:

Diet:

DWR:

Height:

Weight:

Current Illnesses during the past six months

Dental Needs

Date of last Dental Exam:

Findings/Strengths/Needs/Recommendations:

Sedation (HRC Approval):

Immunizations

PPD:

TD:

Hep B Immune:

Pneumovax:

Influenza:

Other:

Other:

COMPREHENSIVE FUNCTIONAL ASSESSMENT
EVALUATION
NURSING/MEDICAL

BRM-MED 615 (6/10)

Name:

C#:

Date of Evaluation:

Date of Last Test Results/Preventative Screening

CBC&DIFF:	TSH:	
U/A:	PAP (if applicable):	
CMP:	PSA (if applicable):	
Other:	Other:	

Medications/Treatments

<i>Order Date</i>	<i>Medication/Treatment (Include Purpose)</i>	<i>Date Modified/Dc'd.</i>	<i>Order Date</i>	<i>Medication/Treatment (Include Purpose)</i>	<i>Date Modified/Dc'd.</i>

Physical Development/Medications

(Seizure medications, lipids, etc.)

Attempts to reduce medications to control behavior over the past year:***Behavior Management Advisory:******Diagnostic Testing/Preventative Screening***

<i>Test/Date</i>	<i>Results</i>	<i>Treatment</i>	<i>Follow-up</i>
Mammogram			
Colonoscopy			
EKG			

Physical Development/Protocols: (Include Strengths/Needs/Recommendations)***Skin Integrity:*** Norton Scale =***Bedrail Assessment:******Risk for Osteoporosis:***

COMPREHENSIVE FUNCTIONAL ASSESSMENT
EVALUATION
NURSING/MEDICAL

BRM-MED 615 (6/10)

Name:

C#:

Date of Evaluation:

Health Need / Diagnosis
(Include Strengths/Needs)

Treatment/
Recommendations

Plan of Care:
Monitoring/Reporting

VII. Cognitive/Self Monitoring:

Functioning level with regards to monitoring one's health, medication administration and ability to schedule one's own medical treatment.

Monitoring/Management of one's own health/medical treatment:

Strengths:

Needs:

Recommendations:

Self Medication Assessment:

Strengths:

Needs:

Recommendations:

III. Sensory Motor Development:

Need for glasses/hearing aid/other adaptive equipment/Care and maintenance of adaptive equipment
Include: Strengths/Needs/Recommendations

Vision:

Audiology:

Health and Safety Supports/Adaptive Equipment:

Mechanical Devices:

Signature/Title

Date

COMPREHENSIVE FUNCTIONAL ASSESSMENT
EVALUATION
NUTRITION

[REDACTED]
BRM-MED 615 (6/10)

Name:

C#:

Date of Evaluation:

Overview

Health history as it pertains to diet and weight -

I. Physical Development:

Body Mass -

Weight -

IWR -

Lipids needs -

Drug Interactions / Side Effects (as relates to nutrition) -

Other -

Strengths:

Needs:

Recommendations:

II. Nutritional:

Appropriate diet determination -

Adequacy of total food intake -

Functional Level with regards to monitor and supervise own nutritional status -

Food Allergies -

Food likes and Dislikes -

Peanut butter Assessment -

Other -

Strengths:

Needs:

Recommendations:

IX. Adaptive Behavior and Independent Living

Dining Skill and functioning level -

Family Style dining Skills -

Other -

Strengths:

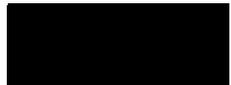
Needs:

Recommendations:

Signature/Title

Date

COMPREHENSIVE FUNCTIONAL ASSESSMENT
EVALUATION
PHYSICAL THERAPY



Name:

C#:

Date of Evaluation:

Overview:

Tools used, etc. -

I. Physical Development/Functional Gross Motor Skills:

Ability to Roll, Sit to Stand, etc-

Ambulation/Gait -

Wheelchair Mobility -

Other-

Strengths:

Needs:

Recommendations:

III. Sensory Motor/Physical:

Reflex Level -

Balance/Equilibrium -

Range of Motion -

Posture -

Muscle Tone -

Muscle Strength -

Other-

Strengths:

Needs:

Recommendations:

Adaptive Equipment:

Walkers, Wheelchairs, LE Orthotics, etc -

Care and Maintenance -

Signature/Title

Date

COMPREHENSIVE FUNCTIONAL ASSESSMENT
EVALUATION
VOCATIONAL



Name:

C#:

Date of Evaluation:

Overview

Work History -

X. Vocational:

Work Interests -

Work Skills (tell time, math skills, verbal skills, etc. -

Work Attitudes (punctual, attendance, motivation, personal appearance, follows instructions) -

Work related behaviors -

Present and future employment options -

Need for Vocational Testing -

Other -

Strengths:

Needs:

Recommendations:

Signature/Title

Date

COMPREHENSIVE FUNCTIONAL ASSESSMENT
EVALUATION
SPEECH



Name:

C#:

Date of Evaluation:

Overview

Tools used -

Receptiveness to evaluation -

V. Speech and Language Development:

Verbal Communication Skills and functioning level -

Non-Verbal Communication Skills and functioning level -

Receptive Communication Skills and functioning level -

Expressive Communication Skills and functioning level -

Need for augmentative or assistive devices -

Oral Motor Function (chewing, sucking, swallowing disorder)-

Articulation (as appropriate)-

Vocal parameters and speech fluency-

Social awareness (conversation skills)

Other -

Strengths:

Needs:

Recommendations:

Signature/Title

Date

COMPREHENSIVE FUNCTIONAL ASSESSMENT
EVALUATION
SOCIAL WORK



Name:

C#:

Date of Evaluation:

Overview

Family History -

IV. Affective Development:

- Interests/personal goals -
- Values -
- Emotional Expression -
- Motivation level/Ability to self-direct -
- Ability to empathize -
- Other -

Strengths:

Needs:

Recommendations:

V. Speech and Language Development:

- Listening Skills -
- Appropriate Communication Skills -
- Other -

Strengths:

Needs:

Recommendations:

VIII. Social Development:

- Interpersonal Skills -
- Guardianship and Advocate information -
- Legal Status (CPL, Vol, Invol., Non-Objecting) -
- Cultural and Ethnic background -
- Religious Preferences -
- Family relationships -
- Other -

Strengths:

Needs:

Recommendations:

Signature/Title

Date

COMPREHENSIVE FUNCTIONAL ASSESSMENT
EVALUATION
PSYCHOLOGY

Name:

C#:

Date of Evaluation:

Overview:

Past intelligence testing, ABS, etc. -

History of behaviors -

History of teaching strategies and/or interventions – (note any target behaviors discontinued which have been mitigated through treatment)

IV. *Affective Development:*

Behaviors (current target behaviors) -

Antecedent behaviors - address behaviors for past year and if improvement is noted identify preventions used

Potential causes of maladaptive behaviors -

Attitudes -

Criminal/legal issues -

Coping skills/frustration and tolerance level -

Need for intrusive techniques and right restrictions -

Ability to empathize -

Effective reinforcers and/or strategies -

Other -

*Strengths:**Needs:**Recommendations:***VII. *Cognitive:***

Ability to process information (i.e. follow 1, 2, 3, step commands, etc) -

Reasoning abilities -

Most recent Intelligence Testing, score, and functioning level -

Ability to give consent to medications -

Ability to give consent to sexual contact -

Ability to give consent to restrictive interventions -

Ability to give consent to right restrictions -

Opportunities and skills in choice and self-management -

Other -

*Strengths:**Needs:**Recommendations:***VIII. *Social Development:***

Supervision level and need for protective oversight -

Other -

*Strengths:**Needs:**Recommendations:*_____
Signature/Title_____
Date

COMPREHENSIVE FUNCTIONAL ASSESSMENT
EVALUATION
HABILITATION



Name:

C#:

Date of Evaluation:

Overview:

Residential and community history -

IX. Adaptive Behavior and Independent Living:

Dining Skills (meal preparation, shopping -

Toileting Skills/Privacy and functioning level -

Dressing and Undressing and functioning level -

Personal hygiene (i.e. combing hair, styling hair, showering, washing hands and face, brushing teeth, flossing teeth, toe and nail care, menses, etc) -

Personal Enhancements (matching clothes, choosing weather appropriate clothing, etc) -

Domestic Skills (household responsibilities, kitchen use, laundry, folding clothes, hanging up clothes -

Money Management, budgeting, PEP -

Travel Skills (past and present history, transportation, community survival skills) as well as functioning ability -

Household Safety Skills -

Other -

Strengths:

Needs:

Recommendations:

Signature/Title

Date

COMPREHENSIVE FUNCTIONAL ASSESSMENT
EVALUATION
AUDIOLOGY



Name:

C#:

Date of Evaluation:

Overview:

Tools used for testing -

Receptiveness to the evaluation -

I. Auditory Functioning:

Extent to which a person can hear -

Maximum use of residual hearing -

Benefits from the use of amplification -

Desensitization to tolerate hearing aides -

Use and care of hearing aides -

Strengths:

Needs:

Recommendations:

Signature/Title

Date

COMPREHENSIVE FUNCTIONAL ASSESSMENT
EVALUATION
ACADEMICS



Name:

C#:

Date of Evaluation:

Overview

School and academic history -

Identify best learning environment (appropriate classroom environment, student/teacher ratios, teacher aide, etc.) -

VII. Cognitive Development

Ability to process information (i.e. follow 1, 2, or 3 step commands, etc.) -

Memory abilities -

Reading abilities (letter recognition, sight words, phonics, spelling, ESL, Vocabulary, Pre academic skills, etc.) -

Math abilities (Number recognition, counting, adding, subtracting, multiplication, division, fractions, percentages, etc.) -

Reasoning abilities -

Other -

Strengths:

Needs:

Recommendations:

Signature/Title

Date

DEVELOPMENTAL DISABILITIES SERVICE OFFICE

Form 34A Med. (Rev.1/02)

NAME: _____ RESIDENCE _____

D.O.B. _____ TABS I.D. NUMBER _____

SERVICE COORDINATOR: _____

ANNUAL MEDICAL ASSESSMENT

DATE: _____

SEX: _____ DATE OF ADM: _____ HEIGHT: _____ WEIGHT: _____

TEMPERATURE: _____ PULSE: _____ RESPIRATIONS: _____ BLOOD PRESSURE: _____

PRIMARY DIAGNOSIS/FUNCTIONAL LEVEL: _____

PAST HISTORY:
OPERATIONS: _____

INJURIES: _____

ALLERGIES: _____

PRESENT HEALTH CONDITIONS:
CURRENT PROBLEMS: _____

BEHAVIOR AND EMOTIONAL STABILITY: _____ PICA: _____

PHYSICAL FINDINGS:
GENERAL APPEARANCE/NUTRITION/AMBULATION: _____

SKIN: _____

HEAD: _____

EENT - INCLUDE HEARING AND GLAUCOMA: _____

NOSE: _____

MOUTH: _____

NECK: _____

CHEST: SHAPE: _____

BREASTS: _____

LUNGS: _____

HEART: _____

ABDOMEN: _____

HERNIA: _____

EXT. GENITALIA: _____ PAP SMEAR: _____ DATE: _____

MENSTRUATION: _____ PELVIC EXAM: _____

RECTAL EXAM: (INCLUDING PROSTATE AND HEMORRHOIDS): _____

MUSCLE/SKELETAL: _____

SPINE: _____

EXTREMITIES: JOINTS: _____

EDEMA: _____ COLOR: _____ PULSES: _____

NERVOUS SYSTEM/REFLEXES: _____

IMMUNIZATIONS: _____

LABORATORY TESTS (LIST ANY ABNORMAL RESULT - USE "WNL" FOR NORMAL RESULTS):

• TO BE PERFORMED ANNUALLY FOR ALL PATIENTS:

CBC AND DIFF: _____

COMPREHENSIVE METABOLIC PROFILE: _____

URINALYSIS: _____

STOOL - OCCULT BLOOD: _____ OVA AND PARASITE, PINWORMS: _____

TUBERCULIN TEST (RESULT AND DATE): _____

CHEST X-RAY (IF INDICATED): _____

IF POSITIVE PPD, ANY EVIDENCE OF ACTIVE TUBERCULOSIS () YES () NO

• AGE-/SEX-DEPENDENT ANNUAL SCREENING:

GYN EXAM/PAP SMEAR - ALL FEMALES AFTER AGE 18: _____

MAMMOGRAPHY - ALL FEMALES AFTER AGE 40: _____

PSA - ALL MALES AFTER AGE 50: _____

E.K.G. - BASELINE AT AGE 50: _____

BONE MINERAL SCREENING - AGE 55 OR OLDER: _____

• OTHER SCREENING TESTS:

HEPATITIS B STATUS/IMMUNIZATION: _____

IF HEPATITIS B CARRIER:

LIVER PROFILE: _____ GASTROENTEROLOGY CONSULT IF ABNORMAL: _____

• OTHER SPECIAL STUDIES (THYROID, DRUG LEVELS, VDRL, ETC.):

CURRENT MEDICATIONS AND DOSAGES _____

CURRENT DIAGNOSIS (SUMMARY OF SIGNIFICANT FINDINGS) _____

TREATMENT PLAN (INCLUDING DIET, CONSULTANT'S RECOMMENDATIONS AND DECISIONS)

MEDICAID CERTIFICATION:

I CERTIFY THAT RESIDENTIAL CARE CONTINUES TO BE MEDICALLY NECESSARY AT THE ICF LEVEL;

() YES

() NO

() N/A

DOCTOR'S NAME (PRINT): _____

SIGNATURE: _____ DATE: _____



DEVELOPMENTAL DISABILITIES SERVICE OFFICE

NAME: _____ RESIDENCE _____

 D.O.B. _____ TABS I.D. NUMBER _____

 SERVICE COORDINATOR: _____

Form34A Med. (Rev.1/02)

ANNUAL MEDICAL ASSESSMENT

DATE: _____

SEX: _____ DATE OF ADM: _____ HEIGHT: _____ WEIGHT: -

TEMPERATURE: _____ PULSE: _____ RESPIRATIONS: _____ BLOOD PRESSURE: _____

PRIMARY DIAGNOSIS/FUNCTIONAL

LEVEL: _____

PAST HISTORY: OPERATIONS:

INJURIES:

ALLERGIES:

PRESENT HEALTH CONDITIONS: CURRENT PROBLEMS:

BEHAVIOR AND EMOTIONAL STABILITY:

PICA: _____

PHYSICAL FINDINGS:

GENERAL APPEARANCE/NUTRITION/AMBULATION:

SKIN: _____

HEAD: _____

EENT - INCLUDE HEARING AND GLAUCOMA:

NOSE: _____

MOUTH: _____

NECK: _____

CHEST:
SHAPE: _____

BREASTS: _____

LUNGS: _____

HEART: _____

ABDOMEN: _____

HERNIA: _____

EXT. GENITALIA: _____ PAP SMEAR: _____ DATE: _____

MENSTRUATION: _____ PELVIC EXAM: _____

RECTAL EXAM: (INCLUDING PROSTATE AND HEMORRHOIDS): _____

MUSCLE/SKELETAL: _____

SPINE: _____

EXTREMITIES: JOINTS: _____

EDEMA: _____ COLOR: _____ PULSES: _____

NERVOUS SYSTEM/REFLEXES: _____

IMMUNIZATIONS: _____

LABORATORY TESTS (LIST ANY ABNORMAL RESULT - USE "WNL" FOR NORMAL RESULTS):

- **TO BE PERFORMED ANNUALLY FOR ALL PATIENTS:**
CBC AND DIFF:

COMPREHENSIVE METABOLIC PROFILE:

URINALYSIS:

STOOL - OCCULT BLOOD: _____ OVA AND PARASITE,
PINWORMS: _____
TUBERCULIN TEST (RESULT AND DATE): _____

CHEST X-RAY (IF INDICATED):

IF POSITIVE PPD, ANY EVIDENCE OF ACTIVE TUBERCULOSIS () YES () NO

- **AGE-/SEX-DEPENDENT ANNUAL SCREENING:**
GYN EXAM/PAP SMEAR - ALL FEMALES AFTER AGE 18:

MAMMOGRAPHY - ALL FEMALES AFTER AGE 40:

PSA - ALL MALES AFTER AGE 50:

E.K.G. - BASELINE AT AGE 50:

BONE MINERAL SCREENING - AGE 55 OR OLDER:

- **OTHER SCREENING TESTS:**
HEPATITIS B STATUS/IMMUNIZATION:

IF HEPATITIS B CARRIER:

LIVER PROFILE: _____ GASTROENTEROLOGY CONSULT IF ABNORMAL:

- **OTHER SPECIAL STUDIES (THYROID, DRUG LEVELS, VDRL, ETC.):**

CURRENT MEDICATIONS AND DOSAGES

CURRENT DIAGNOSIS (SUMMARY OF SIGNIFICANT FINDINGS)

TREATMENT PLAN (INCLUDING DIET, CONSULTANT'S RECOMMENDATIONS AND DECISIONS)

MEDICAID CERTIFICATION:
I CERTIFY THAT RESIDENTIAL CARE CONTINUES TO BE MEDICALLY NECESSARY AT THE ICF LEVEL;

YES NO N/A

DOCTOR'S NAME
(PRINT): _____

SIGNATURE: _____
DATE: _____



Individualized Service Plan

Name of Person: _____ **ISP Date:** _____

Medicaid Number (CIN#): _____

Dates ISP Reviewed	Face to Face?	MSC Initials	Dates ISP Reviewed	Face to Face?	MSC Initials
	YES NO			YES NO	
_____	<input type="checkbox"/> <input type="checkbox"/>	_____	_____	<input type="checkbox"/> <input type="checkbox"/>	_____
_____	<input type="checkbox"/> <input type="checkbox"/>	_____	_____	<input type="checkbox"/> <input type="checkbox"/>	_____
_____	<input type="checkbox"/> <input type="checkbox"/>	_____	_____	<input type="checkbox"/> <input type="checkbox"/>	_____

Section 1: The Narrative

(Profile, the Person's Valued Outcomes and Safeguards)

Profile: Include selected person-centered information about the person discovered during the planning process. For example, abilities, skills, preferences, relationships, health, cultural traditions, community service and valued roles, spirituality, career, challenges, needs, pertinent clinical information, or other information that affects how supports and services will be provided.

Valued Outcomes: List the person's Valued Outcomes that derive from the profile. Outcomes are brief, clearly stated and as specific as possible. Please ensure that there is at least one outcome for each HCBS Waiver Service the person will receive.

Safeguards: List the individualized supports needed to keep the person safe from harm and the actions to be taken when the health or welfare of the person is at risk. Fire safety and evacuation ability is required. In addition, the following areas should be considered: chronic medical conditions, allergies, ability to self-administer medications, special dietary needs, ability to manage finances, ability to give consent, level of supervision required in home and community, ability to travel independently, and safety awareness.

Section 2: The Person's Individualized Service Environment

Natural Supports and Community Resources: List people, groups or organizations that are a resource to the person. For example family, friends, neighbors, associations, community centers, spiritual, school groups, volunteer services, self-help groups, clubs, etc. Include the name of the person, place or organization and a brief statement about what is being done to help the person. Assistance related to achieving a Valued Outcome should be noted.

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Medicaid State Plan Services: Complete a section below for each Medicaid State Plan service including services provided by Article 16, 28, or 31 Clinics. Add more sections as needed. For each service state the **name** of the provider or agency (e.g., Dr. Smith, ARC Day Treatment Center, Southern DDSO Clinic) and the **type of service** (e.g., physician, day treatment, MSC, transportation, durable medical equipment, etc.). For **Clinic services**, for "Name of Provider" indicate the name of the provider and whether the clinic is an Article 16, 28, or 31 (e.g. UCP Article 28 Clinic) and for the "Type of Service" indicate the Clinic service type (e.g, Physical Therapy, Occupational Therapy, Speech Therapy, etc.).

Name of Provider: Type of Service:

Name of Provider: Type of Service:

Name of Provider: Type of Service:

Federal, State or County Funded Resources: Complete a section below for each service. Add more sections as needed. For each service state the **name** of the provider or agency (e.g., VESID, HUD, NYS Office of the Aging, Education Department, BOCES, DOH, Department of Social Services); and the **type** of service (e.g., Senior Citizen Services, educational services, housing). This category does not include Medicaid Funded Services.

Name of Provider: Type of Service:

Name of Provider: Type of Service:

Name of Provider: Type of Service:

HCBS Waiver Services: Complete a section below for each waiver service. Add more sections as needed. For each service state the **name** of the provider or agency (e.g., Sunshine Co. UCP, Southern DDSO), the **type** of service (e.g., residential habilitation, supported employment, environmental modification), the **frequency** of the service (billing unit of service), the **duration** (e.g., on-going), and **effective date** (e.g., 1/1/2010).

Name of Provider:
Type of Service:
Frequency:
Duration:
Effective Date:

Name of Provider:
Type of Service:
Frequency:
Duration:
Effective Date:

Name of Provider:
Type of Service:
Frequency:
Duration:
Effective Date:

Other Services or 100% OPWDD funded supports and Services: Complete a section below for each service. Add more sections as needed. For each service briefly state the **name** of the provider or agency (e.g., Sunshine Co. UCP, Southern DDSO); and the **type** of service.

Name of Provider:
Type of Service:

Name of Provider:
Type of Service:

Name of Provider:
Type of Service:

Signatures:

Service Coordinator: _____ Date: _____

Service Coordinator Supervisor: _____ Date: _____

Person: _____ Date: _____

Advocate: _____ Date: _____

2/2013

OPWDD ARTICLE 16 (PART 679) CLINIC TREATMENT PROGRAM ACTIVITY RECORDING AND NOTES

Individual: Tabs #:	Location of Service:	Discipline:
ICD-9-CM Code/Treatment Diagnosis:	Staff Name/Title:	Staff TABS ID #:

Clinic note must include signature, date and title (Also, explain in Detail therapies or modalities used and status of plan):

Date, 2 Digit [M/D/Y]	Clock Time	Activity Code	Activity Duration Minutes	
	Time In	CL		<div style="display: flex; justify-content: space-between;"> Printed Name/Title/Lic # Date </div>
Location Code:		CL		
	Time Out	CL		
		CL		

DATE ENTERED: _____ INITIAL: _____

VISUAL/PERCEPTUAL SKILLS;

- Accurate reach and grasp
- Able to sit and attend to task without excessive body movements
- Tolerates touch
- Accepts ADL routine without grimacing or agitation
- Walks easily across various floor patterns and textures
- Maneuvers around furniture and objects

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>

ORAL MOTOR:

- Brings/holds head to midline
- Closes lips around spoon to remove food
- Closes lips around cup to intake fluids without excessive spillage
- Moves food in mouth with tongue
- Swallows without difficulty

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>

(Two or more "no" responses in any one section require an appropriate in-depth evaluation)

Name/Title	License #	Date
Name/Title	License #	Date

PT/OT DISCHARGE SUMMARY

Clinical service:	
Name:	
Date of Admission:	Date of discharge:

Reason for Discharge: <ul style="list-style-type: none"> • Terminated upon achievement of outcomes <input type="checkbox"/> • Participant withdrew with notification <input type="checkbox"/> • Participant withdrew without notification <input type="checkbox"/> • Terminated with referral <input type="checkbox"/> • On responsive to treatment <input type="checkbox"/> • Other:
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Course of Treatment
Presenting problems:
Significant treatment outcomes and approaches:
Participant's response to treatment:
Final diagnoses:
Special considerations covering future treatments: (Medications included):
Prognosis:
Referrals made as appropriate:

Clinician's Signature
Clinician's Name/Date
License #

FOR CLINIC USE ONLY:
 CC: Service Coordinator _____ Date: _____ Sent by: _____

Abnormal Involuntary Movement Scale (AIMS)

Patient Name _____ Date of Visit _____

Code: 0 = None 1 = Minimal 2 = Mild 3 = Moderate 4 = Severe

Movement Ratings:

- Rate highest severity observed in category I, II, III.
- Rate movements that occur upon activation one point less than those observed spontaneously.
- Circle movements as well as code number that applies.

		RATER	RATER	RATER	RATER
		DATE	DATE	DATE	DATE
I FACIAL & ORAL MOVEMENTS	1. Muscles of Facial Expression e.g. movements of forehead, eyebrows, periorbital area, cheeks, including frowning, blinking, smiling, grimacing	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
	2. Lips and Perioral Area e.g. puckering, pouting, smacking	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
	3. Jaw Biting, clenching, chewing, mouth opening, lateral movement	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
	4. Tongue Rate only increases in movement both in and out of mouth. NOT inability to sustain movement. Darting in and out of mouth	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
II EXTREMITY MOVEMENTS	5. Upper (arms, wrists, hands, fingers) Include choreic movements (i.e. rapid objectively purposeless, irregular, spontaneous) athetoid movements. DO NOT INCLUDE TREMOR (i.e. repetitive, regular, rhythmic)	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
	6. Lower (legs, knees, ankles, toes) Lateral knee movement, foot tapping, heel dropping, foot squirming, inversion and eversion of foot	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
III TRUNK MOVEMENTS	7. Neck, shoulders and hips Rocking, twisting, squirming, pelvic gyrations	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
IV GLOBAL JUDGEMENT	8. Severity of abnormal movements overall	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
	9. Incapacitation due to abnormal movements	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
	10. Patient's awareness of abnormal movements. Rate only patients report: No Awareness = 0 Aware, no distress = 1 Aware, mild distress = 2 Aware, moderate distress = 3 Aware, severe distress = 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
V DENTAL STATUS	11. Current problems with teeth and/or dentures	YES NO	YES NO	YES NO	YES NO
	12. Are dentures usually worn	YES NO	YES NO	YES NO	YES NO
	13. Endentia?	YES NO	YES NO	YES NO	YES NO
	14. Do movements disappear with sleep?	YES NO	YES NO	YES NO	YES NO

Abnormal Involuntary Movement Scale (AIMS) - Overview

- The AIMS records the occurrence of tardive dyskinesia (TD) in patients receiving neuroleptic medications.
- The AIMS test is used to detect TD and to follow the severity of a patient's TD over time.

Clinical Utility

The AIMS is a 12 item anchored scale that is clinician administered and scored

- Items 1-10 are rated on a 5 point anchored scale.
 - Items 1-4 assess orofacial movements.
 - Items 5-7 deal with extremity and truncal dyskinesia.
 - Items 8-10 deal with global severity as judged by the examiner, and the patient's awareness of the movements and the distress associated with them.
- Items 11-12 are yes-no questions concerning problems with teeth and/or dentures, because such problems can lead to a mistaken diagnosis of dyskinesia.

Examination Procedure

The indirect observation and the AIMS examination procedure are on the following two pages.

Scoring¹

1. A total score of items 1-7 (Categories I, II, III) can be calculated. These represent observed movements.
2. Item 8 can be used as an overall severity index.
3. Items 9 (incapacitation) and 10 (awareness) provide additional information that may be useful in clinical decision making.
4. Items 11 (dental status) and 12 (dentures) provide information that may be useful in determining lip, jaw and tongue movements.

Psychometric Properties

The AIMS is a global rating method. The AIMS requires the raters to compare the observed movements to the average movement disturbance seen in persons with TD. Such relative judgments may vary among raters with different backgrounds and experience.

1. Rush JA Jr., *Handbook of Psychiatric Measures*, American Psychiatric Association, 2000, 166-168.

AIMS Examination Procedure

Either before or after completing the AIMS on the following page, observe the patient unobtrusively at rest (e.g., in the waiting room).

The chair to be used in this examination should be a hard, firm one without arms.

Questions

1. Ask the patient whether there is anything in his or her mouth (such as gum or candy) and, if so, to remove it.
2. Ask about the *current* condition of the patient's teeth. Ask if he or she wears dentures. Ask whether teeth or dentures bother the patient *now*.
3. Ask whether the patient notices any movements in his or her mouth, face, hands, or feet. If yes, ask the patient to describe them and to indicate to what extent they *currently* bother the patient or interfere with activities.
4. Have the patient sit in chair with hands on knees, legs slightly apart, and feet flat on floor. (Look at the entire body for movements while the patient is in this position.)
5. Ask the patient to sit with hands hanging unsupported -- if male, between his legs, if female and wearing a dress, hanging over her knees. (Observe hands and other body areas).
6. Ask the patient to open his or her mouth. (Observe the tongue at rest within the mouth.) Do this twice.
7. Ask the patient to protrude his or her tongue. (Observe abnormalities of tongue movement.) Do this twice.
8. Ask the patient to tap his or her thumb with each finger as rapidly as possible for 10 to 15 seconds, first with right hand, then with left hand. (Observe facial and leg movements.)
9. Flex and extend the patient's left and right arms, one at a time.
10. Ask the patient to stand up. (Observe the patient in profile. Observe all body areas again, hips included.)
11. Ask the patient to extend both arms out in front, palms down. (Observe trunk, legs, and mouth.)
12. Have the patient walk a few paces, turn, and walk back to the chair. (Observe hands and gait.) Do this twice.

Date: _____ Medical record/file no: _____

Patient name: _____

Medication Review Form

N P S

Medication History				Medication Problems	Plan of Action
Medication (generic/brand name and strength)	Prescribed dose/ frequency	Actual dose/ frequency/ method of use	Treatment goal (reason for medication)	Tick those that apply	Actions/instructions to patient eg: dose change, cease, new medication, medication counselling, compliance aids
				<input type="checkbox"/> none <input type="checkbox"/> not aware of medication <input type="checkbox"/> continuing need <input type="checkbox"/> dose/frequency/ formulation <input type="checkbox"/> duplication <input type="checkbox"/> other _____ <input type="checkbox"/> contraindications <input type="checkbox"/> adverse effects <input type="checkbox"/> drug interaction <input type="checkbox"/> serum levels/ biochemistry required <input type="checkbox"/> compliance	<input type="checkbox"/> no change <input type="checkbox"/> action
				<input type="checkbox"/> none <input type="checkbox"/> not aware of medication <input type="checkbox"/> continuing need <input type="checkbox"/> dose/frequency/ formulation <input type="checkbox"/> duplication <input type="checkbox"/> other _____ <input type="checkbox"/> contraindications <input type="checkbox"/> adverse effects <input type="checkbox"/> drug interaction <input type="checkbox"/> serum levels/ biochemistry required <input type="checkbox"/> compliance	<input type="checkbox"/> no change <input type="checkbox"/> action
				<input type="checkbox"/> none <input type="checkbox"/> not aware of medication <input type="checkbox"/> continuing need <input type="checkbox"/> dose/frequency/ formulation <input type="checkbox"/> duplication <input type="checkbox"/> other _____ <input type="checkbox"/> contraindications <input type="checkbox"/> adverse effects <input type="checkbox"/> drug interaction <input type="checkbox"/> serum levels/ biochemistry required <input type="checkbox"/> compliance	<input type="checkbox"/> no change <input type="checkbox"/> action
				<input type="checkbox"/> none <input type="checkbox"/> not aware of medication <input type="checkbox"/> continuing need <input type="checkbox"/> dose/frequency/ formulation <input type="checkbox"/> duplication <input type="checkbox"/> other _____ <input type="checkbox"/> contraindications <input type="checkbox"/> adverse effects <input type="checkbox"/> drug interaction <input type="checkbox"/> serum levels/ biochemistry required <input type="checkbox"/> compliance	<input type="checkbox"/> no change <input type="checkbox"/> action
				<input type="checkbox"/> none <input type="checkbox"/> not aware of medication <input type="checkbox"/> continuing need <input type="checkbox"/> dose/frequency/ formulation <input type="checkbox"/> duplication <input type="checkbox"/> other _____ <input type="checkbox"/> contraindications <input type="checkbox"/> adverse effects <input type="checkbox"/> drug interaction <input type="checkbox"/> serum levels/ biochemistry required <input type="checkbox"/> compliance	<input type="checkbox"/> no change <input type="checkbox"/> action

Medication Review

N P S

Instructions for using this form

This form (consisting of two pages, this page and overleaf) is to assist with the process of a medication review. The form is made up of 5 rows, one row for each medication. **Photocopy this form as many times as is needed for each patient.**

▲ Complete Patient Details

Fill in the date of review, patient name and medical history in the space provided in the box opposite and at the top of the form overleaf.

▲ Medication History

Take a medication history with the patient, then complete the four sections on the form, as outlined below.

1. 'Medication': list all medications currently used regularly or intermittently. Include all prescription drugs prescribed by you and other doctors, over-the-counter medicines and complementary medicines (herbal, alternative and vitamin preparations) as well as medications not previously recorded on your medical records.
2. 'Prescribed': record dose and frequency of medication as prescribed (if applicable) e.g. 10mg at night.
3. 'Actual': record dose and frequency of medication taken by patient eg: 10 mg at night prn when symptoms occur.
4. 'Therapeutic goal': record the desired clinical outcome e.g. target blood pressure level, pain control.

▲ Medication Problems

Tick any which apply, for 'other', specify problems.

▲ Plan of Action

Record action plan e.g. reduce dose, order biochemistry.

For further assistance or information please contact the National Prescribing Service on (02) 9699 4499 or refer to the *Prescribing Practice Review No. 7, on Medication Review*.

Patient Details

Date of review: _____

Patient name: _____

Age: _____ Weight: _____

Allergies: _____

History of adverse drug reactions: _____

Alcohol and tobacco use: _____

Renal function:

Serum creatinine: _____ Estimated Cl_{cr} *: _____

Liver function: _____

*Calculating an Estimate of Renal Function⁵

Renal function declines with age. The estimated creatinine clearance rather than the serum creatinine indicates renal function. Use a formula such as *Cockcroft - Gault* to estimate renal clearance, especially in the elderly who may have a normal serum creatinine

$$\text{Creatinine clearance } Cl_{cr} \text{ (mL/min) (males)} = \frac{(140 - \text{age}) \times (\text{body weight (kg)})}{815 \times \text{serum creatinine (mmol/L)}}$$

(females) = 85% of above

- Creatinine clearance <10 mL/min - renally excreted drugs may be contraindicated
- Creatinine clearance 10-25 mL/min - significant dosage adjustment will be necessary for renally excreted drugs
- Creatinine clearance 25-50 mL/min - most renally excreted drugs will need dosage adjustment

Note this formula is invalid in severe renal insufficiency or with rapidly changing renal function.

Drug Interactions: See www.nps.org.au for information on interactions with the top 10 drugs used on PBS.

Other resources: Australian Medicines Handbook; Therapeutic Guideline series

MEDICATION REGIMEN REVIEW

Name: *****	Date Of Birth: *****
Residence: *****	Date Of Review: 10/04/12
Reviewer/Title: [REDACTED] RPh	Discipline: Pharmacy

Medications & Response to Medications:	Allergies: NKDA
<p>Niacin-TR 250 mg po qhs – (started 4/8/11) Losartan 50 mg po daily – (ordered 3/27/12) – (renal protection)-(b.p.s fine) Vit.-D₃ 2000 i.u. 1 cap po once daily Glimepiride 2 mg po qam – (DM-II) Crestor 10 mg po qhs – (started 9/8/08) Metformin 1000 mg po daily (after dinner) – (DM-II) Debrox Otic Drops 3 gtts a.u. qweekly at hs ASA-EC 81 mg po daily – (cardioprotective) – (started 9/8/08) Risperdal 1 mg po bid Fluvoxamine 50 mg po tid Claritin 10 mg po once daily as needed for allergy S&S Standing Orders: 03/27/12 <u>Interim:</u> Oral Vitamin-B₁₂ ; Folic Acid</p>	

Related Laboratory Tests: - b.m.
<p>04/12/12 – CMP – wnl ; K⁺ - 4.4 ; Alb - 4.2 ; Ca⁺⁺ - 9.2 ; eGFR – 81 HbA1c – 5.3 – (EAG – 105) ; PSA – 1.2 ; TSH – 1.38 / FT₄ – 0.91 CBC – unremarkable ; RBC – 4.11(L) ; MCV – 97.0 Chol – 87 ; HDL – 34 ; Ratio – 2.56 ; LDL – 30 ; TG – 113-(on Crestor 10/Niacin 250) 09/28/11 – Iron – 60 (ref: 60 – 150) ; IBC – 245(L)-(ref: 250 – 450) ; SAT – 24% - (ref: 21 – 38) ; Ferritin – 447(H) 05/05/11 – Iron – 63 ; Ferritin – 518(H) ; Folate – 20.1 ; B₁₂ – 652 03/30/11 – CMP – wnl ; Gluc – 61 ; eGFR – 81 WBC-wnl; RBC - 3.89(L); H&H - 13.0(L)/38.5(L) ; MCV – 99.0(H)/33.5(H)- RDW-wnl TSH – 1.28 / FT₄ – 0.93 Chol – 72 ; HDL – 29 ; Ratio – 2.48 ; LDL – 31 ; TG – 61 – (On Crestor 10 mg) 03/15/11 – CMP – wnl ; Gluc – 80 ; Ca⁺⁺ - 9.1 ; Alb – 3.9 ; eGFR – 74 09/06/10 – HbA1c – 5.2 ; Vit.-D – 59 04/29/10 – HbA1c – 5.3; Vit-D-20; TFT's-wnl ; CK-168(ref: 35 – 232) ; Mg⁺⁺ – 2.4 ; PSA – 0.9 CMP – unremarkable ; Creat – 1.4(H) ; Ca⁺⁺ - 9.4 ; eGFR – 68 Chol – 87 ; HDL – 39 ; Ratio – 2.23 ; LDL – 32 ; Triglyc – 80 – (On Crestor 10 mg) CBC – unremarkable ; RBC – 4.19(L) ; H&H – wnl ; MCV/MCH-sl. elev. 02/11/10 – HbA1c – 5.1 ; Vit.-D Total – 20 06/16/09 – HbA1c – 5.1 03/17/09 – WBC – wnl ; RBC – 3.96(L) ; H&H – 12.9(L)/38.3(L) ; MCV – 96.7(H) HbA1c – 5.1 ; PSA – 1.1 Chol – 98 ; HDL – 39 ; Ratio – 2.51 ; LDL – 43 ; Triglyc – 79 – on Crestor 10mg TSH – 1.39 ; FT₄ – 1.03 04/02/08 – Chol – 162; HDL - 47.3; Lp(a) - 9.0(H); LDL - 100.4; Triglyc - 70; CRP – 0.5 11/15/07 – Chol – 162 ; HDL – 40 ; Ratio – 4.05 ; LDL – 102 ; Triglyc – 98 ; CRP – 0.9</p>

Have any Adverse or Allergic Reactions, Interactions, Contraindications, or Irregularities occurred?
 Yes No **If Yes Please Explain:** Pseudoephedrine may increase O.C. symptoms

Is there a need for a more frequent medication regimen review? Yes No
If Yes, How often should reviews occur?

Reviewer's Comments and Recommendations: *****

06/27/12 – PCP – d/c's B₁₂ & Folate d/t no anemia/poor oral B₁₂ absorption (cardiol.-d/t elev MCV).
 05/31/12 – Urology – renal/bladder u/s – Normal ; still with persistent microscopic hematuria.
 05/22/12 – Urology – microscopic hematuria ; Specimen sent ; Renal/Bladder US with follow-up.
 05/22/12 – Cardiology – orders B₁₂/Folic Acid 500mcg/400mcg s.l. d/t macrocytic cells.
 03/27/12 – PCP – APE – normotensive ; feels reasonably well ; diabetic w/glucoses higher later in the day (over 200 mg%) but better in am-(usually below 100).
 03/08/12 – Psych – Doing well ; sleeping okay ; no med S.E.'s ; AIMS-neg ; no change of meds.
 12/08/11 – Psych – stable weight ; doing well ; sleeping okay ; continue current medications.
 12/05/11 – Ophth – DM-II without retinopathy ; ENS-nlou ; monitor yearly.
 11/22/11 – Neuro-stable; sleeps/eats-well ; OCD-likes things in order ; no-decline ; con't to monitor.
 11/17/11 – ECG – sinus rhythm ; normal ECG ; QTc – 380 ms.
 11/17/11 – Cardiology - ECG – normal ; b.p.-112/76 ; appears well kept ; good pulses ; f/u 6 mos.

-Continue to monitor for signs of blood loss/anemia d/t ASA rx. Continue to monitor for EPS/TD and diabetes due to Risperdal use. Continue periodic monitor of LFT's, muscle pain/weakness, and suggest check CPK in the event myopathy is noted.

*Suggest have cardiology and/or PCP eval dyslipidemia rx dosing as felt appropriate. Based on results below, may wish to consider lower dose of Crestor :

<u>Rx</u>	<u>Chol</u>	<u>HDL</u>	<u>Ratio</u>	<u>LDL</u>	<u>Triglyc</u>	
11/15/07 – No meds	162	40	4.05	102	98	CRP – 0.9
04/02/08 – No meds	162	47	3.45	100	70	CRP – 0.5
03/17/09 – On Crestor 10 mg	98	39	2.51	43	79	
04/29/10 – On Crestor 10 mg	87	39	2.23	32	80	
03/30/11 – On Crestor 10 mg	72	29	2.48	31	61	
04/12/12 – On Crestor & 10 mg /Niacin 250)	87	34	2.56	30	113	

*Suggest discuss benefit/risk (with PCP/Cardiology/Psych) of ASA in combination with Fluvoxamine (SSRI) relative to possible role they may play in persistent hematuria. If decision is made to continue both drugs as currently written, continue to monitor for signs and symptoms of bleeding signs and and revisit this issue should they occur.

Signature:	Date:
Reviewed By:	Date:

Physician / Nurse Follow Up If Required:

Signature:	Date:
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MEDICATION REGIMEN REVIEW

Name: *****	Date Of Birth: *****
Residence: *****	Date Of Review: 10/10/12
Reviewer/Title: [REDACTED] RPh	Discipline: Pharmacy

Medications & Response to Medications:

Allergies: NKA-see adverse reactions(below)

Gemfibrozil 600 mg 2 tabs(1.2gm) po daily-(4:30 pm)
 Vitamin-D₃ 2000 i.u. po daily
 Metamucil 15 ml po bid
~~Debrox Otie Gtts 2 gtts a.u. hs once a week - d/c'd~~
 Zoloft 100 mg po daily
 EC-Aspirin 81 mg po daily
 Multivitamin 1 po daily
 Colace 100 mg 2 caps (200 mg) po qam
 Zantac 150 mg po bid (GERD)
 Artificial Tears 1 gtt o.u. 4xd
 PEG 17 gm po daily
 Duoneb SVN 1 neb q6h prn
~~Loprox TS 0.77% qhs to toenails - (d/c'd Sept-2012)~~
 Dulcolax Suppos 10 mg p.r. if no b.m. x 2 days admin on 2nd day.
 Fleets Enema x 2 prn if no results one hour after use of Dulcolax Suppos per MD order
 Eucerin Lotion to both feet bid and prn
 Zolpidem as presedate
 Standing Orders: 8/16/12
Interim: Adacel-(8/16/12)

Related Laboratory Tests: w.m.

08/21/12 - CMP - unremarkable ; Alk Phos - 135-(H) ; Alb - 3.8 ; Ca⁺⁺ - 9.4 ; eGFR - 80
 TSH - 3.07-(H) / FT₄ - 0.71-(L)
 CBC - unremarkable ; MCV - 98.1-(H) ; RDW - wnl ; Plts - 229K
 11/22/11 - Vit.-D 25-OH - 51.9
 09/20/11 - TSH - 3.47(H) / FT₄ - 0.71(L) ; T₃ & T₄ Total - wnl
 07/19/11 - CMP - unremarkable ; Alb - 3.5 ; Ca⁺⁺ - 8.5-(corrected-8.90) ; eGFR - 72
 Chol - 231 ; HDL - 45 ; Ratio - 5.13 ; LDL - 136 ; TG - 249(H)
 PSA - 1.3 ; TSH - 3.8(H) ; FT₄ - 0.73(L) ; Vit.-D - 27.9(L)
 CBC - essentially wnl ; mildly macrocytic ; EOS - 8.5%(H)
 11/23/10 - CMP - unremarkable ; Alb - 3.4 ; BUN - 25(H) ; eGFR - above 60
 WBC-wnl ; RBC-4.29(L); H&H-wnl ; MCV/MCH - sl. elev ; Plts-127 x 10³(L); EOS-6.8%
 09/29/10 - TSH - 2.71 ; FT₄ - 0.73(L)
 07/16/10 - TSH - 4.34(H) ; FT₄ - 0.87 - (Not on Levothyroxine) ; PSA - 0.9
 WBC - 12.3 ; RBC - 4.11(L) ; H&H - wnl ; MCV & MCH - slightly elevated
 Chol - 149 ; HDL - 41 ; Ratio - 3.63 ; LDL - 78 ; Triglyc - 150
 05/25/07 - Chol - 182 ; HDL - 42 ; Ratio - 4.3 ; LDL - 122 ; Triglyc - 89
 PSA - 0.6

Have any Adverse or Allergic Reactions, Interactions, Contraindications, or Irregularities occurred?

Yes No If Yes Please Explain: Thorazine, Mellaril, Demerol causes low blood pressure/pulse

Is there a need for a more frequent medication regimen review? Yes No

If Yes, How often should reviews occur?

MEDICATION REGIMEN REVIEW**Reviewer's Comments and Recommendations: *******

Dx: Impulse Control d.o. nos / Autism

08/16/12 – Podiatry -- Use Loprox x 1 more month then d/c.

07/30/12 – Psych - NTF

04/20/12 – Psych(██████) - Doing well; Sleep/Appetite-good; Ensure reduced to bid(noted wt gain);
No behavioral complaints ; mood-euthymic ; at behavioral baseline; con't Zoloft 100 mg.

02/03/12 – Podiatry – continue Loprox TS Lotion to all nail plates at bedtime.

01/27/12 – Psych – Sleep/Appetite-good ; behavior at baseline ; continue Zoloft.

12/20/11 – Neuro - f/u cervical spondylosis – doing well ; has no pain ; stable.

11/18/11 – Psych-Doing well; sleep/appetite-good; mood-euthymic; behavior-baseline; con't Zoloft.

08/26/11 – Psych – sleep/appetite – ok ; stable ; see typed report.

07/15/11 – ECG – sinus rhythm ; normal ECG ; QTc – 443 ms.

12/15/10 – Neuro – f/u cervical myelopathy, stenosis ; stable & doing well ; eats/sleeps-well ;
Has no pain ; conservative approach ; will continue present regimen ; f/u 6 months.

12/03/10 – Derm Pathology Report – Rt Chest Mass – dx: cavernous hemangioma.

04/15/10 – ECG – sinus rhythm ; normal ECG ; QTc – 393 ms.

-Continue to monitor for G.I. blood loss and development of anemia d/t heme + stool and
ASA/Zoloft use.

*Psych eval appears in chart for 7/30/12 with note to follow. Please obtain copy of this report.

*With elevated TSH, low FT₄, mildly macrocytic, and every other day use of Dulcolax Suppos,
monitor for clinical signs/symptoms of hypothyroidism (i.e. weight gain, constipation, fatigue,
dry/scaly/rough skin, hair which becomes coarse/brittle and may fall out excessively, sensitivity to
cold). Report any such signs & symptoms to PCP for further eval as appropriate.

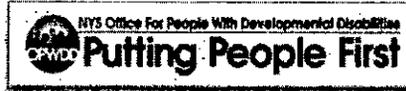
*Given the short elimination half-life of Gemfibrozil, the recommended dose for 1.2 gm per day
dosing would be to split the dose as 600 mg po bid (preferably before breakfast and dinner).
Also, I was unable to locate a follow-up lipid profile since this medication/dose was started.
Recommend appropriate lab follow-up soon if not already done/ordered.

Signature:	Date:
Reviewed By:	Date:

Physician / Nurse Follow Up If Required:

Signature:	Date:
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(4/26/2001)



Restrictive Intervention Application (RIA) Data Form

All Fields Required

INDIVIDUAL INFORMATION

1. Individual Name or TABS ID: **FIRST** = _____ **LAST** = _____ **TABS ID#** = _____

EVENT INFORMATION

2. IRMA Master Incident Number (if available/applicable): _____

PROGRAM INFORMATION

3. Program/Site: _____

4. Program Address: _____

5. Program Type:

- | | |
|--|---|
| <input type="checkbox"/> Autism Unit | <input type="checkbox"/> Free Standing Respite (FSR) |
| <input type="checkbox"/> Center for Intensive Treatment Unit (CIT) | <input type="checkbox"/> Intermediate Care Facility (ICF) – Community Based |
| <input type="checkbox"/> Clinic | <input type="checkbox"/> Individualized Residential Alternative (IRA) |
| <input type="checkbox"/> Community Residence (CR) | <input type="checkbox"/> Local Intensive Treatment Unit (LIT) |
| <input type="checkbox"/> Day Habilitation-Site Based | <input type="checkbox"/> Multiple Disabled Unit (MDU) |
| <input type="checkbox"/> Day Treatment | <input type="checkbox"/> Private School |
| <input type="checkbox"/> Developmental Center (DC) | <input type="checkbox"/> Regional Intensive Treatment Unit (RIT) |
| <input type="checkbox"/> Employment/Work Site | <input type="checkbox"/> Special Behavioral Unit (SBU) |
| <input type="checkbox"/> Family Care Home | <input type="checkbox"/> Small Residential Unit (SRU) |

6. Location: *only one location unless additional interventions result in other locations used.*
If multiple locations are used, check "Other" and explain.

- | | | | | |
|---------------------------------------|-------------------------------------|--|--|---|
| <input type="checkbox"/> Attic | <input type="checkbox"/> Elevator | <input type="checkbox"/> Laundry Room | <input type="checkbox"/> Parking Lot | <input type="checkbox"/> Time-out Room |
| <input type="checkbox"/> Back Yard | <input type="checkbox"/> Foyer | <input type="checkbox"/> Living Room | <input type="checkbox"/> Program Room | <input type="checkbox"/> Treatment Room |
| <input type="checkbox"/> Basement | <input type="checkbox"/> Front Yard | <input type="checkbox"/> Loading Dock | <input type="checkbox"/> Recreation Area | <input type="checkbox"/> Vehicle |
| <input type="checkbox"/> Bathroom | <input type="checkbox"/> Garage | <input type="checkbox"/> Lunch Room | <input type="checkbox"/> Sidewalk | <input type="checkbox"/> Work Area |
| <input type="checkbox"/> Bedroom | <input type="checkbox"/> Hallway | <input type="checkbox"/> Off Facility Property | <input type="checkbox"/> Staircase | |
| <input type="checkbox"/> Dining Room | <input type="checkbox"/> Kitchen | <input type="checkbox"/> Office | <input type="checkbox"/> Swimming Pool | |
| <input type="checkbox"/> Other: _____ | | | | |

RESTRICTIVE PHYSICAL INTERVENTION INFORMATION

7. Select the *most* Restrictive SCIP-R Technique Used (Check only one):

- | | |
|---|--|
| <input type="checkbox"/> One Person Take-Down | <input type="checkbox"/> Two Person Take-Down to Two to Three Person Supine Control |
| <input type="checkbox"/> One Person Take-Down to Side Control | <input type="checkbox"/> Two to Three Person Supine Control |
| <input type="checkbox"/> One Person Take-Down to Seated Control | <input type="checkbox"/> OPWDD Approved Technique: |
| <input type="checkbox"/> Seated Control to Supine Control | <input type="radio"/> Four Person Supine Control [Intensive Treatment Option (ITO)] |
| <input type="checkbox"/> Seated Control to Two to Three Person Supine Control | <input type="radio"/> Five to Six Person Supine Control (ITO's only) |
| <input type="checkbox"/> Two Person Take Down | <input type="radio"/> Individual-Specific restrictive technique: e.g. lift/carry, 4 person supine in a Non-ITO setting, etc. Please explain. |
| <input type="checkbox"/> Two Person Take-Down to Supine Control | |

8. Usage of Physical Intervention: *all that apply* Part of Behavior Plan Emergency Basis

9. Date Physical Intervention Used: _____

10. Time Physical Intervention **Started:** (HH MM) _____ am / pm **Ended:** (HH MM) _____ am / pm

11. Duration of Intervention: _____ **If it exceeds 20 minutes, a 147 form must be filed in IRMA**

12. Reason for Physical Intervention: *all that apply*

- Harming Others Harming Self Person in an unsafe location Other (explain): _____

Other Reason for Physical Intervention: _____

MEDICAL INFORMATION

13. Body Check Performed? Yes No

a. If yes, Name of staff person conducting body check:

FIRST= _____ LAST= _____

b. TITLE:

- | | |
|---|--|
| <input type="checkbox"/> Direct Support Professional | <input type="checkbox"/> Nurse Practitioner (NP) |
| <input type="checkbox"/> Direct Support Professional SUPERVISOR | <input type="checkbox"/> Registered Nurse (RN) |
| <input type="checkbox"/> Residential Manager/House Director | <input type="checkbox"/> Physician Assistant (PA) |
| <input type="checkbox"/> Classroom Aide/Assistant | <input type="checkbox"/> Behavior Specialist/Assistant |
| <input type="checkbox"/> Classroom TEACHER | <input type="checkbox"/> Licensed Psychologist |
| <input type="checkbox"/> Classroom SUPERVISOR | <input type="checkbox"/> Clinician |
| <input type="checkbox"/> Licensed Practical Nurse (LPN) | <input type="checkbox"/> Other _____ |

c. If no - What is the reason? Refused Unknown Called 911 Transported to ER
 Emergent Medical Needs Supersedes Body Check

14. Injury: Was there an Injury?

Yes *If yes, all the injuries from the list below* No Unknown

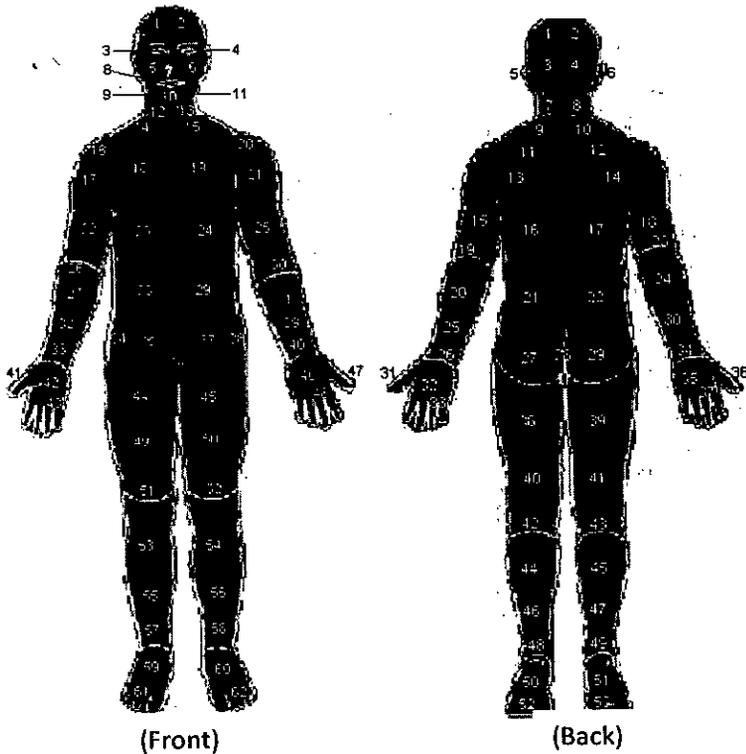
- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Abrasion | <input type="checkbox"/> Redness | <input type="checkbox"/> CONCUSSION | <input type="checkbox"/> LACERATION W/SUTURES |
| <input type="checkbox"/> Bruise/Contusion | <input type="checkbox"/> Scratch | <input type="checkbox"/> DISLOCATION | <input type="checkbox"/> LOSS OF CONSCIOUSNESS |
| <input type="checkbox"/> Hematoma | <input type="checkbox"/> Skin Reaction | <input type="checkbox"/> FRACTURE | |
| <input type="checkbox"/> Laceration without Sutures | <input type="checkbox"/> Swelling | <input type="checkbox"/> INTERNAL INJURIES | |
| <input type="checkbox"/> Puncture | <input type="checkbox"/> Sprain | <input type="checkbox"/> OTHER (only if it meets the Part 624 definition of an injury) | |

If any of the injuries selected are CAPITALIZED, a 147 form must be filed in IRMA.

15. Indicate the Injury Location for the Individual by number(s) found on the

a. Front Body Diagram: _____

b. Back Body Diagram: _____



STAFF INFORMATION

16. Please list up to six (6) staff involved in the physical intervention. Use titles from #13.b:

Staff 1: _____
First Name Last Name Title

Staff 2: _____
First Name Last Name Title

Staff 3: _____
First Name Last Name Title

Staff 4: _____
First Name Last Name Title

Staff 5: _____
First Name Last Name Title

Staff 6: _____
First Name Last Name Title

17. Was Staff Injured as a Result of the Physical Intervention?

- Yes No Yes, Multiple Staff Injured

MEDICATION ADMINISTRATION INFORMATION N/A

18. Date Medication Administered: _____

19a. PRN Medication STAT Medication

20a. Medication Name: _____ Dose: _____ Route: (PO/IM) _____
 (Refer to attached chart for medication name, dose and route.)

21a. Usage of Restrictive Intervention: *all that apply* Part of Behavior Plan Emergency Basis

22a. Time Medication Administered: (HH MM) _____ am / pm

23a. Reason Medication was administered: *all that apply*: Harming Others Harming Self Other (explain):

Other Reason for Medication Administered: _____

19b. PRN Medication STAT Medication

20b. Medication Name: _____ Dose: _____ Route: (PO/IM) _____
 (Refer to attached chart for medication name, dose and route.)

21b. Usage of Restrictive Intervention: *all that apply* Part of Behavior Plan Emergency Basis

22b. Time Medication Administered: (HH MM) _____ am / pm

23b. Reason Medication was administered: *all that apply*: Harming Others Harming Self Other (explain):

Other Reason for Medication Administered: _____

19c. PRN Medication STAT Medication

20c. Medication Name: _____ Dose: _____ Route: (PO/IM) _____
 (Refer to attached chart for medication name, dose and route.)

21c. Usage of Restrictive Intervention: *all that apply*: Part of Behavior Plan Emergency Basis

22c. Time Medication Administered: (HH MM) _____ am / pm

23c. Reason Medication was administered: *all that apply*: Harming Others Harming Self Other (explain):

Other Reason for Medication Administered: _____

TIME OUT ROOM USAGE INFORMATION N/A

24. Usage of Time Out Room: all that apply Part of Behavior Plan Emergency* Basis

*Time Out Room cannot be used on an emergency basis; if so, a 147 form must be filed in IRMA.

25. Date - Time Out Room Used: _____

26. Time Out timeframe: **Started:** (HH MM) _____ am / pm

Ended: (HH MM) _____ am / pm

27. Duration of Intervention: _____ **If duration exceeds 60 minutes a 147 form must be filed in IRMA**

28. Reason for Time Out Room Intervention: all that apply

- Harming Others Person in an unsafe location Other (explain):

Other Reason for Time Out Room Intervention: _____

STAFF INFORMATION

29. Please list up to four (4) staff involved in Time Out Room Usage. Use titles from #13.b:

Staff 1:	_____	_____	_____
	<small>First Name</small>	<small>Last Name</small>	<small>Title</small>
Staff 2:	_____	_____	_____
	<small>First Name</small>	<small>Last Name</small>	<small>Title</small>
Staff 3:	_____	_____	_____
	<small>First Name</small>	<small>Last Name</small>	<small>Title</small>
Staff 4:	_____	_____	_____
	<small>First Name</small>	<small>Last Name</small>	<small>Title</small>

30. Was Staff Injured as a Result of the Time Out Intervention?

- Yes No Yes, Multiple Staff Injured

INCIDENT CATEGORY/CLASSIFICATION

31. Select Category/Class of incident
- N/A
 - Non-Reportable Incidents/Notable Events
 - Reportable Incident _____
 - Serious Reportable Incident _____
 - Allegation of Abuse: _____
 - Mistreatment
 - Neglect
 - Physical
 - Psychological

32. Name and title of staff completing form:

_____	_____	_____
<small>First Name</small>	<small>Last Name</small>	<small>Title</small>

33. Date Form Completed: _____

34. Name and Title of staff reviewing the form:

_____	_____	_____
<small>First Name</small>	<small>Last Name</small>	<small>Title</small>

35. Date Form entered into RIA: _____



STATE OF NEW YORK
OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES

HCBS Form 02.02.97 (5/2010, 4/2011)
Form URAC-2 (4-86)

ICF/MR-LEVEL OF CARE ELIGIBILITY DETERMINATION (LCED) FORM
Please refer to the accompanying instructions for information on completing this form.

Name of Individual		
Address		D.O.B.
Responsible Medicaid District		Status: 620/ 621
Medicaid No (CIN)		TABS ID
Dates of Pre-enrollment Evaluations:	Physical	Social
Psychological		
<i>This information must be kept confidential by recipient</i> ELIGIBILITY DETERMINATION CRITERIA		
1. DIAGNOSIS: A. Mental Retardation <input type="checkbox"/> B. Epilepsy <input type="checkbox"/> C. Autism <input type="checkbox"/> D. Neurological impairment <input type="checkbox"/> E. Cerebral Palsy <input type="checkbox"/> F. Familial Dysautonomia <input type="checkbox"/> G. Other <input type="checkbox"/> (specify:)		
2. DISABILITY MANIFESTED PRIOR TO AGE 22: YES <input type="checkbox"/> NO <input type="checkbox"/>		3. SEVERE BEHAVIOR PROBLEM: YES <input type="checkbox"/> NO <input type="checkbox"/> A. Daily <input type="checkbox"/> B. Weekly <input type="checkbox"/> C. Monthly <input type="checkbox"/> D. Occurred in past 12 months <input type="checkbox"/>
4. HEALTH CARE NEED: YES <input type="checkbox"/> NO <input type="checkbox"/>		
A. Individual has a medical condition which requires daily individualized attention from health care staff		YES <input type="checkbox"/> NO <input type="checkbox"/>
B. Individual displays self-injurious behavior which necessitates monitoring and treatment		YES <input type="checkbox"/> NO <input type="checkbox"/>
C. Individual has deficits in self-care skills		YES <input type="checkbox"/> NO <input type="checkbox"/>
1. Extremely limited self-help skills, requires total assistance with self-care tasks		YES <input type="checkbox"/> NO <input type="checkbox"/>
2. Demonstrates some self-help skills, but requires assistance and training in performing self-care tasks		YES <input type="checkbox"/> NO <input type="checkbox"/>
5. ADAPTIVE BEHAVIOR DEFICIT: YES <input type="checkbox"/> NO <input type="checkbox"/>		
A. COMMUNICATION: YES <input type="checkbox"/> NO <input type="checkbox"/>		
1. Individual has extremely limited expressive or receptive language skills		YES <input type="checkbox"/> NO <input type="checkbox"/>
2. Individual has some expressive or receptive language but requires assistance to communicate needs		YES <input type="checkbox"/> NO <input type="checkbox"/>
B. LEARNING: YES <input type="checkbox"/> NO <input type="checkbox"/>		
1. I.Q. score cannot be determined using standardized test measures (certified untestable)		YES <input type="checkbox"/> NO <input type="checkbox"/>
2. I.Q. score of less than 50		YES <input type="checkbox"/> NO <input type="checkbox"/>
3. Over 21 years of age, person's reading and computation skills are at first grade level or below		YES <input type="checkbox"/> NO <input type="checkbox"/>
4. I.Q. score of 50 – 69		YES <input type="checkbox"/> NO <input type="checkbox"/>
5. Over 21 years of age, person's reading and computational skills are at third grade level or below		YES <input type="checkbox"/> NO <input type="checkbox"/>
C. MOBILITY: YES <input type="checkbox"/> NO <input type="checkbox"/>		
1. Individual is non-ambulatory and totally dependent on staff for moving from one place to another		YES <input type="checkbox"/> NO <input type="checkbox"/>
2. Individual has some mobility skills but needs staff assistance and training to increase his/her capacity for moving about		YES <input type="checkbox"/> NO <input type="checkbox"/>
D. CAPACITY FOR INDEPENDENT LIVING: YES <input type="checkbox"/> NO <input type="checkbox"/>		
1. Individual is completely dependent on others for all household activities		YES <input type="checkbox"/> NO <input type="checkbox"/>
2. Individual needs assistance or training to perform tasks to be a contributing member of household		YES <input type="checkbox"/> NO <input type="checkbox"/>
E. SELF-DIRECTION: YES <input type="checkbox"/> NO <input type="checkbox"/>		
1. Individual exhibits frequent (i.e., weekly) challenging behaviors requiring individualized programming		YES <input type="checkbox"/> NO <input type="checkbox"/>
2. Individual is completely dependent on others for management of his/her personal affairs within the general community		YES <input type="checkbox"/> NO <input type="checkbox"/>
3. Individual exhibits episodic (i.e., monthly) challenging behaviors requiring individualized programming		YES <input type="checkbox"/> NO <input type="checkbox"/>
4. Individual needs assistance or training for management of his/her personal affairs within the general community		YES <input type="checkbox"/> NO <input type="checkbox"/>

See next page for required signatures.



STATE OF NEW YORK
OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES

HCBS Form 02.02.97 (5/2010, 4/2011)
Form URAC-2 (4-86)

Name of Individual:	Medicaid No (CIN):
---------------------	--------------------

Signature of Qualified Person Completing the Form	Review Date
Signature of Review Physician	Review Date

This section to be completed by the DDSO Director (or Designee) for initial LCED determinations only		
Has the OPWDD process for DD Eligibility been completed by the DDSO?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
<input type="checkbox"/> ICF/MR Level of Care Approved Effective (mm/dd/yy):	<input type="checkbox"/> ICF/MR Level of Care NOT Approved	
Date of Waiver Enrollment (mm/dd/yy):		
Signature of DDSO Director (or Designee):	Date (mm/dd/yy):	

Annual ICF/MR Level of Care Eligibility (LCED) Redetermination

The annual LCED redetermination must be reviewed within 365 days from the last review date or the effective date in the field "ICF/MR Level of Care Approved Effective (mm/dd/yy)" above.

By signing below, I affirm that based upon my knowledge of the individual and a review of the most recent psychological evaluation, social evaluation/history, medical history, and the information outlined in questions 1-5, that there has been no significant change that impacts this individual's eligibility for ICF/MR level of care. The LCED is redetermined to be effective for one year (i.e., 365 days) from the signature date below.

Signature and Title of Qualified Person Completing the Form	Review Date

Note: If an individual no longer meets the ICF/MR level of care, the DDSO must immediately be contacted for further action.

PRE-ADMISSION PLAN / INITIAL PLAN OF CARE – BDS-MED 620

The Pre-Admission meeting is conducted to provide information for the interdisciplinary team planning process when an individual enters the Developmental Center. The QMRP ensures that the meeting affords team members the opportunity to become knowledgeable about the individual. The documentation of this meeting will clearly establish an individual's need for receiving treatment and the potential benefit from such services. Treatment services to be provided are clearly documented, using the Initial Plan of Care format. Individual assessments and evaluations are to be current, valid, and support the treatment strategies identified at the time of the pre-admission meeting. Implementation of the Initial Plan of Care is to be clearly documented via the use of data sheets, observation notes, etc. Information gathered as a result of implementing the Initial Plan of Care is used in the development of the initial CFA/IPP. The Pre-Admission meeting is conducted prior to admission; in the event of an emergency admission, the meeting is held no later than the next business day after the admission.

INSTRUCTIONS:

The referring team will ensure the documentation and information provided is current.

1. The referring team will complete the Pre-Admission plan to be sent to the admitting social worker/QMRP and applicable others. (Please Note: The referring team is responsible for completing all but the * (asterisk areas). The admitting team should arrange for a Pre-Admission meeting with the referring team to develop the initial plan of care.
2. The admitting team will conduct the Pre-Admission meeting addressing the implications for treatment and other areas designated on the Pre-Admission Form.
3. If a medical care plan for 24 hour nursing care is to be established by the physician, specify in the physical development and health category.
4. In the final comments of the Pre-Admission Plan/Initial Plan of Care, address the issue of the individual's specific benefit from the level of care he or she is being admitted to (include residence specific criteria).
5. From the completed Pre-Admission plan, assessments provided and information from the pre-admission meeting, the admitting QMRP should ensure that an initial plan of care is written identifying treatment to be received by the individual until the CFA/IPP is completed. (BDS Med 620 or Pre-Admission Meeting form can be utilized to document the initial plan of care.) The Clinical Summary 124 MED is utilized to note the date of the meeting and when the admission will occur. In addition, the following is to be included:
 - a. Attendance for the meeting (a listing of names and job title is sufficient)
 - b. The individual's needs in each treatment domain (utilizing the Pre-Admission Form) sufficient to establish the initial plan of care

- c. Documentation strategy for the needs identified in the initial plan of care – identify which needs require data collection, implementation documentation, etc.
 - d. At the end of the narrative, provide a signature/date for the person completing the Initial Plan of Care and the attending physician; indicate (in writing) above the physician's signature that “the physician has determined that this is an acceptable plan of care at the time of admission”
6. Document on the clinical summary (124 MED) form the date of the pre-admission meeting and the date of admission. Specify that a preliminary plan of care has been established.
 7. Reoccurring admissions or temporary admissions - preadmission document can be updated and revised.
 8. The Pre-Admission meeting documentation is filed in the Plan of Care Section and then purged when the initial CFA/IPP is completed.

Prior to an actual placement, but at a point when all the information is available, a written plan, which is called a Pre-Admission Plan, must be prepared for each person to be placed in another setting. This plan is to identify who will provide services and where the person will receive those services. The plan is to be prepared with the input of:

1. The person whose placement is being proposed
2. The person's correspondent (unless the person is a capable adult and objects to such participation)
3. The person's interdisciplinary treatment team
4. The Revenue Support Agent
5. Designated staff of any future service providers in the community, including the person's anticipated residential facility and day program
6. Designated staff of the local Department of Social Services, if necessary (e.g., the person is on conditional release from a developmental center)
7. Designated staff of the County Mental Health Board (Community Mental Retardation Services) if the person is eligible for and/or needs services from that agency
8. Mental Hygiene Legal Service (MHLS)
9. CAB Representative (for Willowbrook Class individuals)

Please Note: Once the admitting team identifies treatment strategies the result is an initial plan of care to be utilized until the initial CFA/IPP is in place within 30 days of admission.

Documentation which verifies that the initial plan of care was implemented must be maintained.

COMPREHENSIVE FUNCTIONAL ASSESSMENT AND INDIVIDUAL PROGRAM PLAN SUMMARY COVER SHEET – BDS-MED 600

WHAT: Provides documentation of attendance and review of the CFA and IPP
 WHO: The QMRP is responsible to ensure completion of the document
 WHEN: Attendance section is completed at the review meeting by all attendees. The QMRP, TTL, Physician, and Individual signatures at the bottom signify review and acknowledgement of the completed document. The CFA is to be completed and filed, with signatures, within 15 days of the review meeting.
 WHERE: Filed in the Plan of Care Section of the individual's record.

INSTRUCTIONS:

1. The dates of the review are entered, (mo/day/yr). If the date of the IPP is the same as the CFA date, indicate that on the date line with a check on each line. Identify either Initial/Periodic or Special, designating the type of CFA or IPP summary.
2. Attendance (Name/Title): Provide signatures/titles of all individuals attending the case conference. Required Attendance: The individual and his/her guardian/advocate (provide explanation if not in attendance); the treatment team as identified by the TTL must attend the CFA/IPP meetings. The cover sheet should be passed among those attending so that actual signatures are affixed to CFA/IPP documentation.
3. Contributed: Enter the names of those who contributed to the formulation of the CFA/IPP, i.e. individuals served, parents/guardians, family members, significant others, program staff, clinicians, consultants or others.
4. Signatures:
 - a. Signature/Date of the QMRP affirms responsibility for the content of the case conference document in its entirety. The QMRP should review the typed copy to see that what transpired at the CFA/IPP conference is accurately recorded in all areas, and that all necessary information required on the form is completed.
 - b. Signature/Date of the Team Leader review confirms accuracy and completeness of documentation.
 - c. Signature/Date of the Physician's review reaffirms agreement with the total Individual Treatment Plan
 - d. Blank lines are available for use by: Unit Manager/Residence Director/Program Director or others; signature denotes their review of the individual's total treatment plan.
5. Name: Enter the individual's last name, first name, and middle initial.
6. C-Number: Enter the individual's "Consecutive" number.
7. Residence: Enter the name/apartment designation of the primary residence of the individual.
8. Program Enrollment: Enter the name of day program the individual is attending

COMPREHENSIVE FUNCTIONAL ASSESSMENT EVALUATION SUMMARY – BRM-MED 608 (9/10)

- WHAT:** The written record of the CFA and a summary of the IPP. The CFA is a working document reflective of the individual, their needs and strengths, and the team process regarding their active treatment. Both the CFA and IPP contain specific individualized clinical information as discussed by the Treatment Team. The CFA covers the same specific domains for every individual. Each section/domain in the CFA is a narrative of the clinical team's discussion and decisions in the development of the treatment plan. Needs, priority or future (non-priority), identified in the CFA are addressed in the Comprehensive Needs List.
- WHO:** The QMRP coordinates the document, using input from treatment team members. The TTL comprehensively reviews the CFA to ensure that clinical quality is addressed, that it does not contain conflicting information, and that potential barriers to effective implementation of the treatment plan are addressed.
- WHEN:** Within 30 days of admission, and thereafter reviewed and/or modified every 90 days, annually (within 360 days) and as needed (i.e. Special Case Review). The CFA/IPP is updated as often as needed to remain current. Immediately following the meeting, a draft of the new plan, handwritten if applicable and may include Clinical Evaluations, is placed with the Cover Sheet in the record. The completed/ modified document with signatures is to be filed **within 15 days** of the review meeting.
- WHERE:** Filed in the Plan of Care Section of the clinical record.

PREPARATION FOR THE CFA/IPP:

- Every individual served in an ICF must receive a program of continuous active treatment which includes consistent implementation of specialized treatment, training, health and related services to promote the acquisition of the skills and behaviors needed for optimal independence and self determination. When indicated, the individual's program may focus on the prevention of regression or the deceleration of the loss of skills.
- The CFA process depends upon timely sharing of complete and accurate information between all members of the treatment team. Participating clinicians must provide the following specific information to the QMRP on the BRM-Med 615 Clinical Evaluation form **at least 5 days** prior to the CFA meeting:
 1. Developmental history of specified domain – as appropriate, include documentation of past attempts to achieve skills, training attempted, desensitization plans, etc. as well as documentation of less restrictive measures attempted regarding current safeguards or behavioral interventions
 2. Assessment of overall strengths, including relationship of strengths to identified needs

I. Physical Development and Health (including Dental, Vision, Pharmacy)

This domain addresses the individual's development, strengths and needs in the areas of their physical development and health. It will summarize how their physical development and health issues impacts on their active treatment and program plan.

Areas to be addressed include:

1. Medical diagnoses with documentation; identify any new diagnoses and treatment implications
2. Historical illnesses and surgery
3. Medical history, illnesses, surgery in the previous year
4. Potential complications of physical and medical conditions (i.e. immobility, advanced age, etc.). Identify active treatment implications/limitations.
5. Physical growth and maturity compared to chronological age; identify any significant changes (weight gain, weight loss, etc. since previous CFA), and discuss active treatment implications. Does this need to be a new priority need? Is a WTP needed? Document any special meetings held over the past year to address this issue.
6. Immunizations, significant historic information and within past year
7. Diagnostic tests, significant historic and within past year
8. Consults, significant historic and within the past year – indicate recommended follow-up
9. Allergies – include any specific precautions (i.e. epipen)
10. Dental – include need for dentures as well as ability to use and care for them; details of dental exam, including whether sedation was used and it's effectiveness; follow up as recommended, i.e. if poor oral hygiene is noted identify the coordinated response, i.e. will a WTP be developed, will staff oversight be increased to ensure thoroughness, etc.
11. Vision – include need for glasses, when they are to be worn (reading, distance, full-time, etc.), ability/tolerance to wear them, skill level in caring for them. If the individual does not or will not wear them, this is to be identified as a priority need, and a plan is to be developed to address it
12. Bed Safety - document the results of the annual Bed Rail/Bed Safety Assessment. This document must be reviewed and signed every year by the RN. Provide details including recommendations if there are any changes.
 - if bed rails are indicated, document past efforts to ensure safety without the use of bedrails (i.e. lower bed, mats on floor by bed, etc.).

- no mechanical devices (i.e. Posey belts) are to be used to ensure positioning during hours of sleep.
 - if any other type of adaptive equipment, including alarm to alert staff of individual movement, is used to ensure safety at night, it is to be documented in accordance with it's use. If it is a behavioral intervention, it is to be used ONLY within the context of a Behavior Management Plan meeting all requirements (including documentation of which less restrictive measures were tried and why they were ruled out, fading criteria, etc.) and with all required consents.
13. Results of Norton Scale (skin integrity assessment) – document results of the annual assessment (review will be more frequent for those individuals determined to be at risk); if there are treatment implications, identify them clearly (i.e. document that there is a positioning schedule for individual with high risk of breakdown due to a combination of wheelchair use and incontinence; document that there is a monitoring schedule to ensure early detection of compromises in skin integrity for an individual with diabetes and a history of difficult to heal sores on feet, etc.)
 14. Current medications and reasons for use
 15. Drug titration efforts and criteria (particularly psychotropic medications; include relevant historical information and actions taken over the past year)
 16. Level of Self Medication
 - identify preferences (with water, in applesauce, pudding, etc.)
 - identify specifications (i.e. crushed, etc.)
 - identify prerequisite skills acquired and previous steps addressed
 - identify current skills and abilities
 - unless the individual is completely independent in medication administration and/or on no medications whatsoever, a plan must be identified. While data is collected as specified in the plan, the plan must be IMPLEMENTED at EVERY opportunity, i.e. during every med pass at which the identified medication is given. If the plan is not specific to one medication (i.e. pour the water, initial the MAR, etc.), then the plan is to be implemented at EVERY med pass.
 17. Requirements for medication administration (how does the individual take their medication – with water, in food, etc.)
 18. Nursing services required – note any specific areas the RN will be following up on
 19. Discuss continued need for medical orders for health and safety supports (splint for contracture, helmet for seizure, etc.); additionally, document that there is a schedule for use of the equipment, including instructions regarding hours of sleep
 20. Identify placement implications of health care needs – specialized care, equipment, residential requirements, etc. that will be needed
 21. Identify Priority Needs, strengths, recommendations and plans (examples include but are not limited to):

- include information regarding past training attempts, desensitization plans, etc, as appropriate
- if adaptive equipment is used, document that there is a schedule for use which includes instructions for hours of sleep
- if adaptive equipment is prescribed (glasses, dentures, hearing aids, splint, brace, etc.) and the individual does not/will not wear/use it – there must be a plan to encourage use of the equipment
- if adaptive equipment is used, ensure documentation of any medical concerns (for example, splints for an individual with diabetes may require more frequent removal and/or more frequent skin integrity checks than splints for an individual with no other health concerns)
- every individual must have a medication administration plan unless the individual is on NO medications or is already completely independent
- if criteria has been met for a plan or if no progress is being made, the plan must be modified or terminated and replaced to more effectively address the need

II. Nutritional Status

This domain addresses the individual's nutritional needs, current diet, and how they impact on daily life and active treatment needs.

This section will summarize:

1. Prescribed diet consistency with justification, including efforts made historically and within the past year to advance the individual's diet consistency. Clear instruction must be provided to ensure staff can identify what the consistency must look like not only for everyday, but also for a meal or snack when engaging in special activities such as Home Living meal preparation, ordering take out, picnics, restaurant dining, etc.
2. Diet changes made during the past year.
3. An evaluation of prescribed calorie level, weight, weight history, and height in terms of desired weight range, BMI and weight goals, taking into account the person's medical diagnosis, ambulation status, and exercise level. Note any special meetings held to address weight gain or loss
4. Dietary related issues/effect on intake (may include snacking, reinforcers, meal preparation programs, family involvement, etc.). Information regarding diet must give clear direction to staff to ensure diet is followed. Examples include: if CFA states "no concentrated sweets", provide specific examples of what is and is not allowed. For restricted calorie diets, staff must be able to identify what is acceptable for a meal and/or snack when engaging in special activities such as Home Living meal preparation, ordering take out, picnics, restaurant dining, etc.
5. A general description of appetite and usual intake (this may include information regarding sensory-motor needs (i.e. adaptive equipment), behavioral issues impacting on meal ingestion, etc.). Identify special instructions to encourage desired outcome, i.e. alternate food and fluid to ensure maximum fluid consumption.
6. If adaptive equipment is needed, include information on ability to use it. If not independent in use, this will be a priority need, unless there is a clear rationale for not including this as a need. If this need is deferred due to past unsuccessful attempts, consider whether a periodic revisiting of this need is warranted and document results of this discussion
7. When adaptive equipment is indicated, document usage, i.e. available for medication passes and snack as appropriate, if a noney cup is needed to facilitate fluid consumption, one is available for all drinks at the meal and not just one, etc.
8. Likes, dislikes, food allergies, including information on any attempts made to challenge food dislikes and allergies
9. Observation of any religious dietary practices

10. An evaluation of nutritional requirements including any additional vitamin/mineral supplements or commercial supplements
11. An assessment of lab values and their significance
12. Evaluation of potential food/drug interactions
13. If an interdisciplinary feeding assessment has been completed, specify the disciplines involved in the evaluation (typically OT, Speech, Nutrition), the issues addressed (i.e. diet consistency, need for thickened fluids, adaptive equipment, special techniques used) and the recommendations made
14. If thickened fluids are provided, the date and findings of the evaluation should be specified; subsequent 90 day reviews will address continued appropriateness of thickened fluids and individual's fluid intake
15. Peanut butter assessment results – individuals residing at the Developmental Center are not to receive peanut butter until an assessment has been completed and approval given by the dietician
16. Effect of nutritional status on active treatment (as stated above, ensure specific information is present so that the diet (including calorie considerations, consistency, etc.) can be implemented during special events and activities)
17. Results of the Nutrition Risk Assessment – this includes a Nutrition Risk Level designation which determines the frequency of subsequent nutrition reviews: High Risk – quarterly review/annual assessment; Moderate Risk – semi-annual review/annual assessment; Low Risk – annual assessment
18. Identify Priority Needs, strengths, recommendations and plans (examples include but are not limited to):
 - include information regarding past training attempts, desensitization plans, etc, as appropriate
 - if the individual cannot feed himself, a plan to increase independence in this area must be considered; if not identified as a priority need, a rationale must be provided to explain this team decision (this information may be included in the historical information, however, remember that the need may need to be revisited if it has been many years since the last attempt)
 - if adaptive equipment is prescribed to increase independence (built-up spoon, etc.) and the individual cannot use it independently – a plan to teach the use of the equipment must be considered; if not identified as a priority need, a rationale must be provided (this information may be included in the historical information, however, remember that the need may need to be revisited if it has been many years since the last attempt)
 - if criteria has been met for a plan or if no progress is being made, the plan must be modified or terminated and replaced to more effectively address the need

III. Sensorimotor Development

This domain addresses muscular and skeletal development and needs such as physical skill, dexterity, fine and gross motor coordination and perceptual abilities.

This section will summarize:

1. Gross motor skills, including ambulation. If needs in this area, provide recommendations for enhancing/maintaining abilities in this area; for example, if not ambulatory, is he/she able to self-propel wheelchair, and is this beneficial to overall well being. If so, is it a need (no if engages in the activity at the desired level without intervention; yes if training and/or structured interventions are needed to accomplish the task).
2. Fine motor skills
3. The effect of the above on daily activities including ADLs – include specific information regarding individual's current skills and abilities in regards to the personal skills identified in W 242 (toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs). If not independent in these areas, a need must be identified, or a rationale must be provided
4. Effect of motor skills on individual's functioning across all settings (in the Developmental Center and in the community)
5. Adaptive equipment including why, how and when it is used
6. Placement implications including environmental modifications needed, etc.
7. Identify Priority Needs, strengths, recommendations and plans (ex. include but are not limited to):
 - include information regarding past training attempts, desensitization plans, etc,
 - if needs are identified related to an individual's ability to complete ADLs, this area must be considered for plan; if not identified as a priority need, a rationale must be provided to explain this team decision
 - if adaptive equipment has been prescribed or recommended (splint, brace, etc.) and the individual does not/will not wear/use it – there must be a plan to encourage use of the equipment (desensitization)
 - if adaptive equipment is prescribed to increase independence (walker, cane, brace etc.) and the individual is unable to use it independently – a plan to teach the use of the equipment must be considered; if not identified as a priority need, a rationale must be provided (this information may be included in the historical information, however, remember that this may need to be revisited – inability to master a skill many years ago may not be indicative of current potential)
 - if criteria has been met for a plan or if no progress is being made, the plan must be modified or terminated and replaced to more effectively address the need

Note: If an interdisciplinary feeding assessment has been completed, the results will be included in the Nutritional Status section as indicated in #13 of that domain.

IV. Affective and Behavioral Development and Needs

This domain addresses the behavioral and emotional needs of the individual and how they impact on active treatment needs.

This section summarizes:

1. Maladaptive/Dysfunctional Thoughts, Emotions, Behaviors
 - a. Describe each specific condition, emotion, behavior that needs to be the focus of attention and treatment.
 - b. Target behaviors – identify all target behaviors which are subject to restrictions, interventions, supports; and/or which staff need direction to address. Target behaviors must be defined in observable terms, as the words used to describe many maladaptive behaviors are often vague; for example, "agitation" or "assault" may present in many different ways. The clinician must provide clear, observable, measurable descriptions by which the target behavior is recognized (speech becomes louder or more rapid, the individual paces rapidly, pulls at clothing, bites, pinches, kicks, etc.)
 - c. Provide information on the frequency, intensity, duration, and the personal and interpersonal impact of the thought/emotion/ behavior.

2. Functional Analysis/Antecedents and Hypotheses – if there are clear or hypothesized antecedents and/or reasonable hypotheses about external and internal stimuli or events which influence the target behavior, describe these for each behavior which requires protective measures and/or interventions.

3. Protective Oversight/Safeguards – These are the restrictions that need to be imposed on the individual to ensure the safety and security of the individual as well as the well-being of others.
 - The rationale for protective oversight and safeguards (personal and environmental) must be stated for each, and must be clearly linked to each target behavior. Note that a single target behavior could have several measures of protective oversight/support, but the rationale and need for each must be articulated.
 - When restrictive interventions have been previously attempted, describe these and their results.
 - When psychotropic medications are being used to address behavioral needs, each medication must be clearly linked with specific behavioral needs.
 - When psychotropic medications are used, there will be documentation of the discussion resulting in the determination that the risks of the harmful effects of the behavior outweigh the potentially harmful effects of the drugs.
 - When adaptive equipment is used, it must be clearly linked to a specific observable behavior. When need for the equipment has passed (i.e. criteria is attained and equipment is no longer used) it must be removed from the CFA, the treatment plan and the HRC approval form.
 - When adaptive equipment is used, specific parameters for use must be provided, i.e. under what conditions is the device used (when what behavior is seen?), when is it removed, instructions for use during hours of sleep, etc.

- When everyday materials are withheld, monitored, or otherwise restricted, it must be clearly linked to a specific, observable behavior. Examples include withholding silverware, restricting or monitoring phone use, restricting or monitoring TV use, etc. When the need for the restriction has passed, it must be removed from the CFA, the treatment plan and the HRC approval form.
 - Sensors and/or alarms used to monitor movement due to behavioral concerns must be addressed in accordance with the requirements of this section
 - Any intervention (even when it is necessary to protect the health and safety of the individual or others) which restricts the rights of the individual must meet **all** requirements as identified in this section, and include all required consents. Consents (written Informed Consent and HRC approval) must be obtained **PRIOR** to the implementation of any rights restrictive intervention, including medication.
4. Supervision Levels – identify supervision levels on the unit, in the building and in the community by making reference to the standard supervision protocol of the unit, and include special supervisory arrangements for the individual which his target behaviors or environment necessitate.
 5. Other Interventions, Treatments or Considerations (if applicable) – any psychosocial treatments the individual is receiving and considerations not captured elsewhere, which are important components of the individual’s psychosocial habilitation.
 6. Impact on Placement -- discuss impact of behavioral issues on placement, including supports that will be needed for successful community placement
 7. Identify Priority Needs, strengths, recommendations and plans (examples include but are not limited to):
 - include information regarding past training less restrictive interventions attempted, etc., as appropriate
 - if rights are restricted, they must be addressed.
 - in this domain, as criteria is met, fading is often indicated. Ensure that fading is planned and occurs as identified in the plan
 - if no improvement is noted, the plan must be reviewed and the team must determine whether or not modification is needed

*** Rights restrictions may be imposed only in the context of a behavior management plan as identified in this manual, and as regulated by Parts 483, 633.16, 633.4, and 624. Rights restrictions must be identified, incorporated into a plan meeting all requirements, and are implemented only **AFTER** informed consent and HRC approval has been obtained. Ensure that the documentation describing these interventions match in all areas (CFA, Functional Analysis, WTP, HRC, etc.)

*** It is imperative that all team members recognize what constitutes a “rights restriction”. Rights restrictions are not only SCIP takedowns or time-out, but also the restricting of

everyday items (like silverware) and activities (like inclusion outings), or the monitoring of activities that would typically be given privacy (like phone use). Use of commercially available clothing may be a rights restriction when the person cannot easily remove it themselves, and it is used to restrict access to a body part. Sensors and/or alarms used to alert staff to an individual's movements due to behavioral concerns are rights restrictions. There are many times when it is not only appropriate, but imperative that these restrictions be implemented, however, they may be implemented only in the context of a behavior management plan as discussed above.

*** Please note – in an emergency, refer to Emergency Procedures – Broome P/P 2.19. Ensure the safety of individuals and staff, and report the need to use Emergency Procedures to the appropriate team members as identified in the Policy.

*** False Allegation of Abuse Protocols may be implemented only in the context of an approved Behavior Management Plan, developed in accordance with all requirements found in Part 624 and Broome P/P 2.17 Appendix I. Any such protocol may be implemented only AFTER all appropriate consents have been obtained (Informed Consent, Human Rights Committee (HRC) consent, and Special Review Committee (SRC) consent). All approved protocols provide instructions for staff which ensure all appropriate protections are afforded to the individual when an Allegation of Abuse is made, and ensures that such protocols are clinically justified.

V. Speech and Language Development

This domain addresses the ability of the individual to communicate with others.

This section summarizes:

1. Expressive language skills.
2. Receptive language skills.
3. Oral motor development including an oral peripheral assessment.
4. Articulation and fluency of speech.
5. Use of a communication device or non-verbal communication. The team must address the need to ensure that communication needs are met across all settings. For example, if the individual uses a communication board with symbols or pictures that are used to communicate needs, this board must be available to the individual at his residence and in the program area
6. If non-verbal, an assessment of the individual's potential for use of augmentative communication.
7. Reading skill level.
8. Relationship of communication skills to other areas of active treatment.
9. Identify Priority Needs, strengths, recommendations and plans (examples include but are not limited to):
 - include information regarding past training attempts, etc., as appropriate
 - if adaptive equipment is recommended to increase independence (augmentative communication device, etc.) and the individual cannot use it independently – a plan to teach the use of the equipment must be considered; if not identified as a priority need, a rationale must be provided
 - if the individual has demonstrated capacity, interest, or desire to communicate using sign language, consideration of a plan must be demonstrated. If a plan is not identified, a rationale must be provided
 - if criteria has been met for a plan or if no progress is being made, the plan must be modified or terminated and replaced to more effectively address the need

Note: If an interdisciplinary feeding assessment has been completed, the results will be included in the Nutritional Status section as indicated in #13 of that domain.

VI. Auditory Functioning

This domain addresses hearing abilities.

This section summarizes:

1. Hearing test date and results
2. Middle ear functioning
3. Developmental level of auditory skills
4. The impact of hearing abilities upon communication and everyday activities, provide specific active treatment recommendations. Examples may include how to speak to maximize effectiveness (i.e. doesn't hear well on left side, high pitched sounds are hard to hear, etc.).
5. Medical follow-up completed or required
6. Hearing aid use including level of independence, consistency of use, and any plans for training in use or care of the hearing aid
7. Identify Priority Needs, strengths, recommendations and plans (examples include but are not limited to):
 - include information regarding past training attempts, desensitization plans, etc., as appropriate
 - if a hearing aid is used and the person cannot use or care for it independently, a plan to teach the use or care of the equipment must be considered; if not identified as a priority need, a rationale must be provided
 - if a hearing aid is recommended and the person will not wear it, a plan must be in place to encourage use of the recommended equipment
 - if criteria has been met for a plan or if no progress is being made, the plan must be modified or terminated and replaced to more effectively address the need

VII. Cognitive Development

This domain addresses general mental functioning. Of special importance is the relationship between cognitive abilities and daily functioning in the environment (e.g., unit, classroom, work site, or community).

This section summarizes:

1. Specific needs including more than test results, identifying the basis for further skill development, including but not limited to:
 - choice-making skills – choice making skills may be reinforced from the most basic level (a preferred vs. a non-preferred item) to very complex choices (budgeting, health issues, etc.); provide examples to assist staff in promoting choice making throughout the day for all individuals regardless of skill level)
 - need for sex education
 - ability to answer yes/no questions
 - money skills – ability to budget (may be limited, but an individual that does not understand the “accounting” or math part of it may still be able to identify something he/she would like to save for, which is a component of budgeting); include concept/usage of money; emphasize that even those individuals with no number concepts may be able to learn some part of the concept of money, i.e. that it is traded for something more desirable
 - phone skills (able to dial the number independently, etc.)
 - ability to handle own mail (reading skills, etc.)
2. Academic skills may be identified here, or in the Vocational/Education section.
3. This category also addresses the individual's ability to give consent:
 - a. Within 30 days of admission or when needed, a psychologist completes a BDS-Med 623-(Revised 3/2000) – documenting an individual's capacity to provide informed consent to (1) psychosocial treatments including rights restrictive/intrusive interventions, (2) medications, (3) medical procedures/surgical interventions, (4) placement, (5) physical intimacy/sexual relations, and (6) notifications regarding incident reporting and access to records. (NOTE: Ability or lack of ability to give consent in one area does not necessarily indicate ability or lack thereof in another area.) Additionally, even within one area, an individual's ability to give consent may vary. An individual may be able to give consent for a simple medical procedure in the doctor's office (removal of a wart), but unable to understand the risks and benefits of a more complicated procedure or intervention such as major surgery, chemotherapy, etc.
 - b. At the CFA, the team discusses the psychologist's determinations and recommendations. The QMRP then documents the individual's capacity to provide informed consent in the domains listed in paragraph 1 above (see example below).
 - c. Changes in the individual's capacity to provide informed consent are noted in progress statements and when the CFA is updated.
 - d. The QMRP will ensure the CFA is updated to reflect change in the individual's ability to give informed consent when a competent individual reaches the age of legal majority (eighteen years old); and ensures that the actual consent for

treatment/rights restrictions is updated (i.e. consent is obtained from the individual) when a competent individual becomes of legal majority (eighteen years old).

EXAMPLE CAPACITY TO PROVIDE INFORMED CONSENT

Due to Mr. ___'s cognitive and communicative deficits (his IQ is 12 to 21 and his expressive and receptive language are minimal), he is unable to give consent for psychosocial treatments, medications, medical/surgical procedures or for placement. He is also considered to be unable to give consent for physical intimacies of any kind including sexual relations. Mr. ___ is unable to comprehend the risks and dangers of his conduct to self and others, and he is unable to understand the benefits and risks associated with varying forms of behavioral treatment, including intrusive interventions and psychotropic medications. Mr. ___ would not be able to accurately evaluate potential placement opportunities as they may pertain to his immediate and future well-being. Mr. ___'s mother, Ms. ___, maintains contact with staff at this facility to inquire about Mr. ___'s care. Mr. ___ is not able to comprehend the meaning of incident reporting information, or access to his records. Ms. ___ is the "qualified person" for purposes of access to records and incident reporting. At this time, Ms. ___ gives informed consent for all services and interventions provided to Mr. ___.

4. Identify Priority Needs, strengths, recommendations and plans (examples include but are not limited to):
 - a plan must be considered for any person without money skills; if not identified as a priority need, a rationale must be provided. At a minimum, a plan addressing prerequisite skills must be identified. Examples may include money use, i.e. someone that cannot understand the number concepts – how much each coin is worth – may be able to understand that when you put it in the machine in the cafeteria, you get a soda. A clear connection between the prerequisite skill and money management/money skills must be identified.
 - for persons with prerequisite skills, work to develop plans that would enhance independence and privacy (i.e. someone with number skills may learn to use a phone without staff assistance with dialing)
 - choice-making is a "building block" skill for many other skills, including communication; consideration should always be given to the need for a choice-making plan for those individuals with deficits in this area
 - if criteria has been met for a plan or if no progress is being made, the plan must be modified or terminated and replaced to more effectively address the need

VIII. Social Development

This domain addresses needs that relate to interaction with others. The need might relate to large or small group involvement, the individual's ability to control his/her own behavior in a social setting, and/or areas of need in self-direction and choice making during leisure time opportunities.

This section summarizes:

1. Family/Advocate/Legal Guardianship
 - a. Describe level of participation in the life of the individual (visitation, participation in CFA/IPP process, participation in placement planning, etc.). Discuss QMRP's efforts to promote such involvement
 - b. For Willowbrook Class individuals, include involvement of CAB
 - c. If an individual is regarded as incapable of making decisions on their own behalf, are over the age of 18 and do not have a legal guardian, the QMRP must make documented efforts at least annually to inform parents or other interested parties of the steps to take in pursuit of guardianship (refer to Broome DDSO Policy 1.4)
 - d. Identify "qualified person" (may be the individual) to receive notifications regarding reportable incidents and access to records; include name, address and phone number.
2. Legal status – note voluntary, minor voluntary, involuntary, probation, etc.
3. Religion – identify preferences and provide adequate information so that staff are able to support the individual to worship as he or she chooses. Services are to be appropriate to meet the standards expected within the identified religion to the greatest extent possible, for example, expected participation in a weekly Catholic Mass is on Saturday evening or on Sunday
4. Include recreational services/activities, both organized and on one's own, which a person enjoys participating in – identify opportunities for positive practice for WTPs (LIT TRIPS form will highlight activities and success on identified outings). Include reference to specialized nutrition needs that may be necessary (consistency, calorie restrictions, etc.) – it is not necessary to repeat them (they are identified in the Nutrition section), however, include a reference/reminder that the individual does have needs in this area that must be considered on outings or at special events
5. Individual and civil rights, voting skills and individual's interest in voting. Include any training that has been provided on the voting process and making educated choices.
6. Identify Priority Needs, strengths, recommendations and plans (examples include but are not limited to):
 - often plans from many other domains are reinforced during the social activities described in this section. Provide specific information for staff for opportunities for positive practice (OPP) (Examples – "attending Mass provides excellent OPPs for Sue's Attending and Behavioral WTPs; be sure to provide reinforcement for meeting criteria established in those plans." "Going to bowling league provides Bob with

opportunities to implement his community safety plan; encourage him to look both ways before crossing the street.”).

- if criteria has been met for a plan or if no progress is being made, the plan must be modified or terminated and replaced to more effectively address the need

IX. Adaptive Behavior and Independent Living Skills

This domain addresses the individual's ability to function in daily life. Information for individuals with significant cognitive or physical disabilities may focus on basic daily living skills such as eating, dressing and grooming. Information for those with more skills will address the skills they need to develop for increased independence in community living.

This section summarizes:

1. Skills and needs regarding activities of daily living (particularly those described in W242), including documentation of past efforts to teach basic daily living skills; additionally, these areas must be revisited periodically (the inability to acquire a skill many years ago is not necessarily an accurate predictor of potential today)
2. Toileting skills – if not independent in toileting, training in prerequisite skills should be discussed; if a toileting plan is not implemented due to the individual's past inability to learn the skill, the CFA must include documentation of the efforts made and the rationale for discontinuation of this training. Additionally, this area must be revisited periodically (the inability to acquire a skill many years ago does not automatically mean that area should not be attempted again).
3. Dining and food preparation skills – include cooking, setting table, cleaning up, etc.
4. Laundry skills – include pouring detergent, sorting lights and darks, etc.
5. Phone skills – note ability to dial, hold phone, any restrictions on calls, etc.
6. Room care – include dusting, putting things away, making the bed, etc.
7. Fire evacuation skills, needs and considerations including description of current capacity for evacuation; expectations for improvements; training emphasis
8. Money skills (if not covered in the Cognitive Development section), including ability to carry money and sign ledger; budgeting skills; identify how money concepts and usage will be developed and reinforced if the individual has no money skills (may include prerequisite skills being developed; a clear connection between the prerequisite skill and money management/money skills must be identified); encourage recognition that putting money in the machine in the cafeteria gets a soda, etc.
9. Travel skills including ability to use public transportation, difficulties encountered in traveling in a van or bus, recognition of "stranger danger", etc.
10. Placement implications of individuals needs and skills
11. Identify Priority Needs, strengths, recommendations and plans (examples include but are not limited to):
 - include information regarding past training attempts, desensitization plans, etc., as appropriate

- for any person without money skills a plan must be considered; if not identified as a priority need, a rationale must be provided. At a minimum, a plan addressing prerequisite skills must be identified. Examples may include money use, i.e. someone that cannot understand the number concepts (i.e. how much each coin is worth), may still benefit from working on a plan designed to increase understanding that when you put the coins in the machine in the cafeteria, you get a soda
- for persons with prerequisite skills, work to develop plans that would enhance independence and privacy (i.e. someone with number skills may learn to use a phone without staff assistance with dialing). A clear connection between the prerequisite skill and the skill being developed must be identified
- choice-making is a "building block" skill for many other skills, including communication; consideration should always be given to the need for a choice-making plan for those individuals with deficits in this area
- if criteria has been met for a plan or if no progress is being made, the plan must be modified or terminated and replaced to more effectively address the need

X. Vocational Skills/Education

This domain addresses the individual's training or preparation for training in employment. For individuals under the age of 21, it includes information about their educational program and plans.

This section summarizes

1. Vocational interests – identify what the individual would like to learn to do
2. Vocational skills – include previous jobs and/or training
3. Employment skills
4. Work for Pay evaluation and experiences – include information on ability to handle/ budget the money earned – may refer to other domain(s) if it is addressed there (i.e. Cognitive; Adaptive Behavior and Independent Living Skills)
5. Educational program and goals – building on previous training and skills developed, including academics. Utilize IEPs and previous WTPs to continue building on strengths, i.e. reading skills, math skills, etc.
6. Placement implications of individuals skills, needs and desires regarding employment, as appropriate
7. Identify Priority Needs, strengths, recommendations and plans (examples include but are not limited to):
 - include information regarding past training attempts
 - if criteria has been met for a plan or if no progress is being made, the plan must be modified or terminated and replaced to more effectively address the need

Placement / ICF Level of Care

This section summarizes the placement plan. At the 30 day meeting, and thereafter at each 90 day and annual review, the Treatment Team must conduct an assessment of the appropriateness of a community placement for each individual served in the Developmental Center. This assessment will include a comprehensive assessment of needed services and supports.

If an individual has a history of behaviors which place self or others at risk, the Treatment Team shall assess whether a community placement option can be considered at this time, or whether the individual continues to need the support, structure and intensive treatment provided in a developmental center. When the Treatment Team determines that an individual needs the structure, support and intensive treatment provided in a developmental center, the Treatment Team will also specify the behavioral changes, treatment progress and/or areas of skill acquisition needed for the individual to live safely and successfully in a community setting.

Individuals identified as appropriate to move to a community setting will have a DDP 4 entered into TABS to reflect the team recommendations and record any stated preferences. When placement is imminent include a plan for the services needed for the individual to succeed in the community. This will ensure consistency and continuity in planning with other agencies.

This section will:

1. Describe the need for continued ICF level of care and current day program, including the expected benefit
2. Discuss the individual and family's interest in community placement, including any stated preferences regarding specific services and/or providers. In the event of an identified prospective provider, representatives from the prospective provider agency should participate in the development and implementation of the individual's plan; and should be invited to participate in treatment plan review meetings. This participation is to be documented.
3. Include any additional requirements and/or preferences for community placement including location and level of care. Needs/preferences to consider include locale (i.e. county/city/town preference), residence type (i.e. an apartment, small group home, supported residence), accessible features (ramp, hand rails, etc.), housemate(s)/no housemate, type of neighborhood – (quiet, large yard, access to open space, access to public transportation, shopping within walking distance), etc.
4. Detailed description of supports/services needed – examples may include environmental modifications (ramps, hand rails, etc.), supervision levels (due to medical or behavioral needs), travel and community access considerations, specialized treatments, access to worship services of their preference, day services, access to social/recreational venues of their interest, etc.
5. For Willowbrook Class members, there is to be documentation that the availability of Willowbrook entitlements has been considered
6. Treatment Team's recommendation for appropriate community placement
7. Placement screenings
8. Trial visits to other placements including the individual's response to the visits
9. If specific needs are cited as reasons for current level of care, those needs must be addressed (i.e. objectives identified as priority needs)

Needs, recommendations and plans

Environmental Safeguards and Supervision Needs

The Treatment team will, at the time of admission, assess the individual to determine their level of supervision. This determination will be based on information from the Pre-Admission Meeting/Initial Plan of Care, the individual's response/adjustment to his/her new living environment, input from the physician, nurse, and other team members, and, once developed, the Functional Analysis. If the consumer's needs can be met through provision of "Standard Supervision" for their residential unit, the CFA will note this information. Standard levels of supervision are defined for each location including the frequency of visual contact, ratio of staff to individuals and the proximity of staff when making/maintaining visual contact. If Standard Supervision is not sufficient to meet the consumer's needs, his behavioral or medical needs enhanced supervision will be discussed. The consumer's Level of Supervision will be reviewed as needed, but at a minimum at the time of the initial and annual case conferences and in each 90 day review thereafter (refer to Broome DDSO P/P 9.14 for Supervision/Enhanced Supervision Policy). NOTE: Supervision grids may be utilized to supplement/summarize this information. Guidance provided in supervision grids is to be in agreement with information in the individual's CFA (e.g. if CFA states "standard supervision", supervision grid should not identify "direct supervision"). However, the supervision grid may be used as the tool to identify the specific staff ratio required across a variety of specific settings which may not be specifically identified in the CFA.

This section will summarize information required to safeguard the individual in all environments:

1. Supervision level is described in clear, measurable, observable terms:
 - a. Example A: Mr. Smith requires periodic observation every 15 minutes while on the apartment, every 5 minutes during off- apartment activities on grounds, and within range of scan ratio 1 staff to 3 individuals in the community.
 - b. Example B: Miss Smith must have arms length supervision for all activities in the kitchen. Miss Smith needs to be kept at least 2 feet away from hot surfaces.
2. Supervision level for use of kitchen and bathroom, including: stove usage, use of hot water, safe handling of sharp objects and use of kitchen appliances:
 - a. Example C: Mr. Smith cannot be within 5 feet of boiling water
 - b. Example D: Miss Smith cannot have access to sharp objects, including kitchen knives as she has no awareness of common dangers.
 - c. Example E: Mr. Smith requires an apartment with locked cupboards due to extreme pica behavior.
3. Identify any specific supervision needs the individual may have when traveling in a car, bus or van. The individual's supervision needs in community settings should also be specified.
4. Identify supervision needs and special considerations during overnight hospitalization. Hospital staffing provided by the DDSOO is based on individuals' needs/status and may vary throughout the hospital stay. (Refer to Broome DDSO Policy 4.6 Assessment, Treatment, or Placement with a Medical Provider and Nursing Policy

H-5-2 Protocol for Individuals Who are Hospitalized). An individualized hospitalization coverage protocol may include considerations such as forensic status, history of elopement, anxiety level, and family/advocate participation. Hospital coverage 24 hours per day is not the standard, staffing is based both on the needs outlined in the CFA, as well as the individuals status at time of hospitalization.

Placement implications of supervision and safeguarding needs

Privacy

This section summarizes the individual's privacy needs. This information may also be found in the Medical Orders and/or Risk Management Plan as appropriate. In all cases, when individuals are bathing, toileting, dressing, undressing, grooming, etc., personal privacy will be provided, unless specific and documented restrictions are in place with appropriate medical or behavioral needs specified to justify such restrictions. Any restrictions on privacy will be specified in the CFA and supported by appropriate documentation such as HRC consents.

When present, describe any limitations in the following privacy areas:

1. Limitations in access to privacy areas within the DC and on the apartment.
2. Restrictions to privacy during visits or during personal care
3. Mail or phone restrictions (with appropriate plans and consents)
4. Specify the individual's needs which lead to these restrictions and the team's recommendations and plans to address the needs (these will typically be addressed in the domain the need arises from – refer to information found in those sections as appropriate).

5. Individual Resource Issues

This domain addresses financial/resource considerations:

1. Eligibility for resources including Medicaid, Medicare and Social Security is included; specific account balances are not included
2. Availability of any trust funds (not including balances)
3. Personal Expenditure Plan (PEP) – note goals for spending, note if the individual saving for something special
4. Burial plans
5. Person-owned bank accounts and individual's participation in banking – individuals with money skills and ability to understand may be considered for a person-owned bank account.
6. Plans for use of or acquisition of resources
7. Placement implications of resource issues, if any
8. Identify Priority Needs, strengths, recommendations and plans (examples include but are not limited to):
 - include information regarding past training attempts
 - if criteria has been met for a plan or if no progress is being made, the plan must be modified or terminated and replaced to more effectively address the need

IPP SUMMARY:

This section will summarize identified priority needs and provide the focus for active treatment.

The successful delivery of quality services in the context of the ICF/483 service environment is dependent on the quality of the IPP. This section:

- demonstrates that clinically sound assessments have been completed by tying the strengths and needs of the individual together into a cohesive plan that is supported by the documentation, observation, and interview
- demonstrates that those assessments were used by the treatment team to develop appropriate treatment plans
- provides effective direction for staff to implement active treatment
- demonstrates that the QMRP is effectively monitoring the plans, and ensuring that plans are modified and/or discontinued when they have been successful and criteria is met, or when they are no longer effective

Health interventions/nursing services should be summarized including focus on any identified as priority needs. At a minimum, medications, health and safety supports, adaptive equipment (evidence of continued appropriateness), diet and supplements are to be addressed.

For each WTP, include the rationale, time and place of implementation, and opportunities for positive practice. Opportunities for positive practice (OPPs) exist naturally throughout the day at times and places other than the identified WTP implementation schedule. Provide concrete examples of OPPs to ensure consistency across sites and shifts.

Discussion of the WTP addressing Behavior Management is to include mention of the interventions identified which are rights restrictive (include any interventions with HRC approval, i.e. mechanical restraints, SCIP-R interventions, time-out, etc.).

The **focus of active treatment** will include a discussion of the individual's needs and how treatment results in the acquisition of skills necessary for the individual to function with as much self determination and independence as possible. It will include opportunities for individual choice and self management and will discuss the relationship of the treatment plan to the individual's identified needs. The IPP summary will summarize how the individual's WTPs are integrated into their treatment plan, and how those WTPs are integrated into their everyday life, resulting in "active treatment".

Describe the level of family and individual's participation in the CFA/IPP process, attendance at the CFA annual meeting, opportunities to contribute as part of the team process.

Document the annual review of Individual Rights completed with the individual/advocate.

COMPREHENSIVE NEEDS LIST – BDS-MED 605

- WHAT:** A list of all needs as determined by the Treatment Team at the CFA. All needs are identified as prioritized or non-prioritized. Priority needs are those which are currently being formally addressed. When needs are non-prioritized to be addressed in the future, a rationale is provided, i.e. developmental readiness or physical incapability (a person may be temporarily incapable of participating in a WTP), developmental sequence (a person would benefit first from attaining a prerequisite skill); or significant events yet to be achieved by the individual. The team may determine that due to a person's current life circumstances, an additional priority need would be stressful or counterproductive in the individual's current active treatment program.
- WHO:** The QMRP
- WHEN:** Initiated at the initial IPP conference; at each subsequent conference, the list is reviewed by the Treatment Team, and updated by the QMRP based on the current individual needs as determined through the CFA/IPP process
- WHERE:** In the Plan of Care Section of the of the individual's clinical record.
The Comprehensive Needs lists are not purged with the CFA.

INSTRUCTIONS:

1. Individual Name: In the designated space, enter the individual's full legal name (last name, first name, middle initial)
2. C-Number: Enter the individual's "Consecutive" number
3. Date: The QMRP will identify the established date of the needs list consistent with the date of the IPP meeting.
4. Priority Needs: Enter the priority needs which were discussed during the CFA and categorized as priority at the IPP.
5. Objective: Enter the Long Term Objective for the Written Training Plan addressing the need.
6. Future Needs: Enter the future (non-priority) needs which were discussed during the CFA and categorized as non-priority at the IPP.
7. Rationale: Non-prioritized needs are to include a rationale discussing reason(s) for deferring formally addressing the need.
8. Terminated: When needs are terminated, complete the date and reason for termination.

REMINDER: As needs are added to the need list, they can be hand written with an effective date. When needs are terminated, they can be dated and designated as "terminated" in hand written form. The needs list serves as on-going historical documentation and does not get purged.

TREATMENT SCHEDULE – BDS-MED 602

- WHAT:** Provides an ongoing summary of the individual's Treatment/Services.
- WHO:** The Treatment Schedule is completed by the person identified at the review/case conference.
- WHEN:** The Treatment Schedule is initiated upon admission and reviewed monthly and as needed when treatment schedule changes are made.
- WHERE:** Filed in the Active Treatment Section of the individual's legal record.

INSTRUCTIONS:

1. **Name:** Enter individual's full legal name, last name first
2. **C-Number:** Enter the individual's Consecutive Number
3. **Start Date:** The date upon which this schedule goes into effect is to be entered in the designated blank space
4. **End Date:** The date upon which this schedule ceases to be in effect is to be entered in the designated blank space. The end date should be entered and a new Treatment Schedule completed
5. **Location:** Enter individual's residence/unit/program in the designated blank space.
6. **PRN Objectives:** Enter by name any prn WTPs. Examples may include WTPs addressing behaviors, toileting, etc.
7. **Time Block:** Each represents an activity/program (e.g. Recreation/Leisure Time Activities, ADLs, Communication, Relaxation Therapy, etc.)
8. **Time/Day:** Each "box" on the Treatment Schedule form represents a one hour block of time, with the specific hours designated in the left hand column. Therefore, a box opposite the hour "11:00 a.m." indicates a period that runs from 11:00 a.m. to 11:59 a.m., with the next box starting the 12:00 noon hour period. To specify an activity/program that runs through a quarter or half hour of a time period, a line would be drawn horizontally across the box at the appropriate location ($\frac{1}{4}$, $\frac{1}{2}$, or $\frac{3}{4}$ of the box). Therefore, if an individual were to attend Speech Therapy from 11:00 a.m. to 12:15 p.m. on Monday, then the entry would be made in the 11:00 a.m. box in the Monday column giving the activity name, and a horizontal line would be drawn across the 12:00 noon box one-fourth of the way down. To further clarify the schedule, an arrow would be drawn from the entry delineating the 12:15 p.m. termination. Boxes are not to be divided into less than fifteen minute intervals. If an activity/program is scheduled for the same time each week day, this information may be shown by entering the activity/program name in the Monday box and drawing an arrow across to the right hand side of the Friday box.

9. Changes: Alterations may be made on the form when minor permanent changes in the individual's schedule occur. Minor changes are no more than 2 changes per day on the schedule. If the schedule changes significantly, the end date is entered in the designated blank space, and a new Treatment Schedule is completed. Changes are made by making one (1) horizontal mark across entry. Enter new information, initial and date.

QMRP MONTHLY SUMMARY – BRM-Med 503A

- WHAT:** Summarizes pertinent information regarding the 30 day period since the last review
- WHO:** The QMRP
- WHEN:** This review must occur within 30 days of the previous CFA/IPP review (whether it was an annual, 90 day review, or 30 day review)
- WHERE:** Filed in the Plan of Care Section of the clinical record

CONSIDERATIONS:

In preparation for the review, the QMRP reviews the individual's record for the following issues. In all cases, if not current and appropriate, the CFA is modified:

- Program objectives, progress, regression, modifications
- Money management, opportunities to spend/earn money
- Behavior Support Plan, changes since last review
- Medical concerns
- Inclusion, opportunities to participate in the community
- Family involvement, contact
- Significant events, special events occurring over past 30 days

INSTRUCTIONS:

1. Name: Enter the individual's last name, first name, and middle initial
2. C-Number: Enter the individual's "Consecutive" number
3. Month/Year: Enter month and year review is addressing
4. Date of Review: Enter date review is completed
5. Enter a summary of the QMRP review of the issues identified above.
6. Signature line is provided for the QMRP for signature, title, and date

QMRP QUARTERLY SUMMARY – BDS-MED 609

- WHAT: Summarizes pertinent information regarding the 90 day period since the last review
- WHO: The QMRP
- WHEN: This review must occur within 90 days of the previous CFA/IPP review (whether it was an annual or a 90 day review)
- WHERE: Filed in the Plan of Care Section of the clinical record

CONSIDERATIONS:

In preparation for the review, the QMRP reviews the individual's record for the following issues. In all cases, if not current and appropriate, the CFA is modified:

- Legal status
- Changes in identified needs
- Treatment Schedule
- Family involvement, contact
- Significant events, special events occurring over past 90 days
- Money management, opportunities to spend/earn money, PEP
- Inclusion, opportunities to participate in the community

- In conducting the review, the QMRP:
 - Verifies corrective action on any concerns noted in the periodic review
 - Summarizes overall progress/change(s) in the individual's status, including any changes made to WTPs over the course of this 90 day period

Ascertains if any new priority needs were developed. If yes, enter in long hand on the Comprehensive Needs List. Reviews entire list of needs to determine action to be taken. Documents decisions and rationales regarding priorities. Documents any additional comments as appropriate.
- Placement:
 - Once a specific placement opportunity or plan has been identified, progress towards accomplishing this placement is reviewed and documented as needed, but at least at each 90 day review. Projected date of placement and the individual's, family members, and advocates response to the plan is to be included. If a provider has been identified, a representative from the prospective provider agency should be invited to participate in development and implementation of the plan, and in treatment plan review meetings
 - If community placement is not indicated, identify and document which skills and/or supports are needed prior to community placement being considered. Progress towards addressing these skills and/or supports is documented in the annual and 90 day review until such time as a community placement referral is deemed appropriate.
 - For families who do not participate in 90 day reviews, the team must make contact with the family to discuss team decisions and get their input (unless the individual objects), and document this discussion

- Consideration must be given to the following placement planning elements:
 1. Living Arrangements – needs/preferences to consider include locale (i.e. county/ city/town preference), residence type (i.e. an apartment, small group home, supported residence), accessible features (ramp, hand rails, etc.), roommate(s)/no roommate, type of neighborhood – (quiet, large yard, access to open space, access to public transportation, shopping within walking distance), etc.
 2. Health – discuss any issue that may impact on placement; health related services that will have to be established or accessed in the community
 3. Financial – identify current sources of income; projected income when living in the community; anticipated financial supports necessary in a community setting
 4. Day Services – identify preferences - work, sheltered workshop, day habilitation, etc.; identify skills needed to accomplish this; services and supports necessary for successful transition to the program of choice
 5. Social/Recreational – identify types of activities the individual likes to engage in; training needs and supports individual needs for participation in chosen activities; any specific organizations the individual chooses to participate with
 6. Family – discuss family involvement; identify any concerns; are they supportive of the individual's choices?; if the individual approves, involve family/advocate in meetings regarding placement plans; include date of last substantial contact
 7. Transportation – identify any specialized needs; public transportation, wheelchair van, etc.
 8. Religion – identify desired level of participation in services or related activities; preferred service type and location; transition to new location for religious services
 9. Behavior – discuss current treatment, plans and supports in place to assist in developing acceptable behavior in the community; treatment, plans and supports that will be required in a community placement; ensure that the plan addresses appropriate and available supports to address any behaviors which place self or others at risk
 10. Program Goals – identify goals in place to assist individual to prepare for community placement; program goals planned after move
 11. Placement Efforts – list the dates and participants of the individual's referrals; meetings with potential providers; screenings that have occurred since the last meeting with dates over the previous year

INSTRUCTIONS:

1. Name: Enter the individual's last name, first name, and middle initial
2. C-Number: Enter the individual's "Consecutive" number
3. Quarterly dates the review is addressing
4. Date review is completed
5. Participant signatures of everyone attending quarterly review

6. Indication of notification and attendance of the individual
7. Signature line is provided for the Individual, QMRP, RN, TTL for signature, title, date
8. Enter a summary of the QMRP review of the issues identified above.
9. The RN will provide a quarterly summary of the health care issues to be incorporated into the QMRP quarterly.
 - At a minimum, the Medical summary will include a review of:
 - Diagnosis, new diagnoses and treatment implications
 - Immunizations, labs, consults, appointments within past quarter
 - Diet and weight
 - Current medications and reasons for use
 - PRNs Administered within last 90 days
 - Adaptive devices
 - Self Medication/Management
10. The Psychologist will provide a quarterly summary of the behavioral issues and the Behavioral Support Plan to be incorporated into the QMRP quarterly.
 - At a minimum, the Psychology summary will include a review of:
 - Rights Restrictions and Fading status
 - Frequencies of behaviors
 - Status of Objectives (progression/regression/modifications)
 - Replacement behaviors
 - Supervision Levels
 - False Allegation of Abuse protocol (only if applicable)
11. File in the Plan of Care Section of the clinical record

WRITTEN TRAINING PROGRAM – BRM-MED 610 (5/10)

- WHAT:** The Written Training Program (WTP) is designed to address priority objectives; provide clear directions for staff working with the individual on how to implement the teaching strategies; and provide a measurable method of assessing progress toward the desired objective.
- WHO:** The clinician identified for providing training to the individual as a result of the IPP meeting will complete this form. The clinician will be responsible for the quality, delivery and evaluation of the WTP. It should be noted except for those facets of the IPP that must be implemented only by licensed personnel; each individual's program plan must be implemented by all staff working with the individual, including professional and paraprofessional staff.
- WHEN:** Once agreed upon, development of the WTP begins immediately
- WHERE:** Filed in the Active Treatment section of the individual's clinical record

INSTRUCTIONS:

1. **Name:** Enter the individual's last name, first name, and middle initial
2. **C-Number:** Enter the individual's "Consecutive" Number
3. **Need:** List the Need relative to the goal as identified on the IPP. The need to be addressed must be clearly stated so as to be consistent with the IPP.
4. **Strengths:** List appropriate strengths to support and justify the Long Term Objective
5. **Long Term Objective** – must be based on needs identified in the CFA. There must be a clear link between specific objectives and functional assessment data and recommendations. Must be stated separately, in terms of a single behavioral outcome, each discrete behavior is assigned a separate objective. They may address services to be provided, learning/treatment needs, adaptive equipment, etc.
6. **Short Term Objectives** are incremental steps organized in a developmental progression that work toward achieving the Long Term Objective. They are specific, measurable, short term, single, observable behaviors that are expected to be met within a 3-6 month period.

The information in the objectives is the starting point from which the effectiveness of the intervention for promoting positive skill acquisition is measured. This section has a minimum of three components:

- a. **Observable Behavior** – a single behavior (or skill) which the individual does or does not exhibit, which requires training to allow for more independent functioning. This statement must be written so that observers can reliably identify whether the behavior has/has not occurred.
- b. This observable behavior (what can be seen) must also be in measurable terms (prompt level, trials/or percentage, number of months). This may not be a percentage only – data used to arrive at the percentage must be included.

c. Start date and target date for only the LTO and the Short Term Objective being worked on currently. LTO is always within 360 days of the start date of the plan. Plans should be written such that it is reasonable to expect the long term objective will be attained within one year.

7. Name and title of the staff responsible for monitoring the goal, and the resource person for staff implementing the goal.
8. Titles of all staff expected to implement the goal.
9. Name and title of the QMRP.
10. Identify equipment and materials necessary to implement the WTP. This may include reinforcers for the individual, instructional materials, etc. Additionally, identify health and safety supports if needed, for example to maintain proper body position, balance or alignment, mechanical devices utilized in behavior management, adaptive equipment, etc.
11. Rationale: Describe the purpose of the WTP as it relates to:
 - a. Supporting the individual's movement towards independence
 - i. skill development – a plan designed to teach the individual a specific skill
 - ii. prerequisite skills – it is often necessary to focus on basic, “prerequisite” skills for certain individuals. When this is the case, ensure that there is a clearly documented connection between the prerequisite skills and the desired final skill (i.e. money management, medication administration, etc).
 - b. Development of opportunities for individual choice and self-management
 - c. Relevance to the individual
12. Baseline: the frequency, duration and/or intensity of the behavior prior to the implementation of the written treatment plan.
13. Reinforcement: indicate what type of reinforcement(s) to use for this plan, as well as reinforcements that are ineffective (as needed). To promote consistency every time the service is delivered, use specific verbal directions “Joe, your clean room looks great!” or a physical “Lightly rub Sue’s shoulder.”
14. Schedule: The schedule represents when and where implementation of the methodology will occur. Plan should be implemented at all appropriate times – if it is a med goal, then at every med pass.
15. Methodology: Provides clear directions for staff working with the individual on how to implement the teaching strategies. The specificity must be such that any other person, not ordinarily involved, could implement this method with consistency. Steps should be short and simple, in bulleted or numbered format, and include what both the staff and the individual are expected to do.
16. Opportunities for Positive Practice: The clinician should indicate suggested activities and/or opportunities to implement the WTP and/or support the targeted skill (both the

current objective and previously learned related skills) in both formal and informal settings. For example, someone with a current objective to learn the ASL gesture for "eat" should be prompted to sign "eat" at all appropriate opportunities throughout the day, AND should also be prompted to use the signs he has previously learned as well. Opportunities should naturally occur in the normal rhythm of the day. Provide ideas for the staff to implement the goals throughout the day, taking advantage of "teachable moments".

17. Data Collection: A specific statement providing clear directions to any staff person working with the individual about the type of data to record, and the frequency which data is to be recorded
 - a. The method by which the data of the individual's progress is documented must yield accurate measurement of the criteria stated in the individual's IPP objective
 - b. Data should be collected with enough frequency and enough content that it can measure appropriately the individual's progress and performance
 - c. Plus/Minus should only be used in rare instances
 - d. When it is anticipated that the plan will necessitate the collection of data at multiple sites, the author of the plan is to indicate, in this section, the specific locations at which data will be collected and will identify the data keeping materials to be maintained at each site. When the goal-related activity is expected to occur at multiple sites, data collection can occur at representative locations

18. Data Review: Frequency that data will be reviewed by clinician; for example, daily in the classroom, weekly on the apartment. This is demonstrated by putting their initials and the date on the data sheet.
A monthly review of the data will be completed and recorded on the monthly progress note.

19. Signature of Clinician: The Clinician supervising the WTP design and implementation is to sign and date on this line and thereby affirms responsibility for the content, training of all implementers on all shifts and at all sites, and continuous monitoring through completion of the progress statements.

d.

PROGRESS STATEMENT – BDS-MED 611 (5/10)

- WHAT: The means of monitoring the individual's progress toward meeting the stated objective of the WTP
- WHO: The clinician responsible for the WTP
- WHEN: At least monthly and summarized quarterly as long as the WTP is in place
- WHERE: Immediately follows the last page of the WTP (in the Active Treatment section) or any preceding progress statements in chronological order

INSTRUCTIONS:

1. Name: Enter the individual's name
2. C-Number: Enter the individual's "Consecutive" number.
3. Name of WTP
4. Start date of WTP
5. Long Term Objective as specified in the WTP
6. Baseline as specified in the WTP
7. For 1st/2nd/3rd monthly progress:
 - a. STO Letter: Enter the letter of the short term objective currently being addressed
 - b. STO: Short Term Objective as specified in the WTP
 - c. Month/Year for which progress is being assessed, the cycle which the statement covers (not to exceed 30 days in length)
 - d. Data Collected: Statement of individual's progress or lack of progress in behavioral/measurable terms (quantitative statement). The behavioral statement should relate to all components of the WTP. Percentages are acceptable if trial based. Also included is the number of interventions for the time period specified above; if delivery of intervention is less than prescribed, an explanation must be given
 - e. Ensure the data correlates with the measurable terms in the short term objective
 - f. Progress or lack of progress since the last month's summary
 - g. Narrative: A narrative discussing progress or lack of progress which includes reference to previous performance or baseline data. The individual's response/behavior must be described in such a way that it relates directly to the objective. Include a rationale for regression or no progress. Narrative should include comments regarding opportunities, activities, and experiences the individual was exposed to which may have enhanced/ reinforced the training program.
 - h. Action Taken: Indicate by checking one, and only one, of the five boxes labeled:
 - "Continue" – Continue as written
 - "Modify" – Change or update the methodology, materials, supports, etc. as outlined in the narrative above

"Discontinue" - Plan is discontinued with the approval of the Interdisciplinary Team

"Suspend" - Temporary suspension due to hospitalization, decompensation, extended home leave/vacation, etc.

"STO met" - If criteria is met, the STO must be replaced with a new STO/plan, building on the previously learned skills

Progress is assessed by comparing data from the present recording period with data from the previous recording period. If regression is noted, the plan must be modified/updated, or a rationale provided for continuation of the plan. If criteria is met, the plan must progress to the next STO and/or be terminated. If this need is now considered to be met, the Needs List must be updated, with appropriate action taken (i.e. development of new plan if a new need is identified).

8. For quarterly progress statement:

a. STO Letter: Enter the letter of the short term objective currently being addressed

b. Months/Year for which progress is being assessed, the cycle which the statement covers (not to exceed 90 days in length)

c. Quarterly Data Summary: Statement of individual's progress or lack of progress in behavioral/measurable terms (quantitative statement) over past quarter. The behavioral statement should relate to all components of the WTP.

d. Progress or lack of progress since the last quarter's summary

e. Narrative: A clinical interpretation of the data summary, including progress or lack of progress and reference to previous performance or baseline data. The individual's response/behavior must be described in such a way that it relates directly to the objective. Include a rationale for regression or no progress. Narrative should include comments regarding opportunities, activities, and experiences the individual was exposed to which may have enhanced/ reinforced the training program.

9. Signature: The clinician who completed the progress statement will enter their signature, title, and date of signature

INFORMED CONSENT FOR RIGHTS RESTRICTIVE / INTRUSIVE BEHAVIORAL TREATMENT – INTERVENTIONS OR MEDICATIONS FOR BEHAVIORS – BRM-MED 618

- WHAT:** Provides documentation of Informed Consent and Human Rights Committee (HRC) approval for use of WTPs which include rights restrictive interventions
- WHO:** The psychologist ensures documentation of approvals; typically the psychologist procures Informed Consent (Informed Consent may be from the individual, surrogate, or the Informed Consent Committee depending on the circumstances of the individual); once Informed Consent is obtained, the plan is presented to HRC for approval
- WHEN:** Both Informed Consent and HRC approval must be obtained PRIOR to implementation of the WTP
- WHERE:** Documentation of Informed Consent and HRC approval is documented in the designated space for each on the form; the form is filed in the Active Treatment / Psychology Section of the record

Informed Consent Process:

1. The individual/guardian/surrogate is informed of the intended intervention, including all rights restrictive elements
2. If medication is being recommended, the risks and benefits are described in a manner and language best understood by the individual/guardian/surrogate
3. The QMRP will ensure that the consent for treatment/rights restrictions is updated (i.e. consent is obtained from the individual) when a competent individual becomes of legal majority (eighteen years old).

When the individual provides Informed Consent:

1. Signs and dates the form in the designated place
2. If the individual objects, the intervention (including medication) may not be utilized unless authorized by a court order

When an individual has a legal guardian, family member or other authorized person identified as giving Informed Consent for plans which restrict rights:

1. The psychologist attempts to notify that individual, more than one time and in more than one way, regarding the need for consent; these attempts are documented
2. Attempts can be a phone call when need for consent is imminent; however, a written follow-up must be completed contemporaneously when the attempt is a phone call
3. Verbal consent is not appropriate for routine renewals of behavior management plans. The consent process must be initiated far enough in advance to procure written Informed Consent prior to the current consent lapsing. Verbal consent is appropriate when a consult results in the physician/psychiatrist recommending a prompt change to a new medication, as treatment should not be delayed while waiting for the written consent.

4. Notification attempts must be documented in the individual's record either through filing copies of correspondence in the Correspondence Section of the record or through a written entry in the staff notes section of the record; this entry needs to include date, method and results of attempts.
5. When multiple attempts to contact the person who gives consent are unsuccessful, the psychologist presents the plan to the Informed Consent Committee for discussion and action
6. The psychologist attempts to notify the person who normally consents that the plan has been presented to the Informed Consent Committee, the results of the committee's discussion and action and the right to disagree with the committee's recommendation; all such efforts are documented in the manner noted above.

Human Rights Committee (HRC) Consent:

1. Once Informed Consent is in place, HRC consent is procured. The psychologist presents the Behavior Management Plan in full, to include all restrictive interventions (medications, SCIP-R, time out, etc.) to the committee for approval. No rights restrictive interventions meant to modify maladaptive behavior may be approved except in the context of a behavior management plan, meeting all requirements stated in the 483 Interpretive Guidelines and 633.16, including identification of the functional analysis, proactive strategies, replacement behaviors, and fading criteria. Psychotropic medications may not be approved unless there is justification that the harmful effects of the behavior outweigh the potentially harmful effects of the drugs.

1. The review process includes at least all of the following elements:
 - a. The review is to include any changes (progress/completion) or problems (regression/non-implementation) with active treatment priority needs. If a consumer has attained the skill, the WTP must be terminated and/or modified to ensure that an appropriate need is being addressed. If the individual is losing skills already gained (i.e. if regression is being noted), identify what modifications will be made to the plan. The QMRP can summarize in writing that a review has been conducted; treatment information is updated only as necessary. In the event of a new admission – verify documentation of implementation of the Initial Plan of Care is available.
 - b. Results of meetings, observations, consumer/QMRP interactions or staff interviews can be noted and are used to ensure active treatment is occurring across sites and shifts, and that noted preferred activities are occurring, including:
 - participation in preferred worship services – ensure that staff and individual's are able to state what services are attended, and that the answers match the preferred services as identified in the CFA. Services are to be appropriate to meet the standards expected within the identified religion, for example, expected participation in a weekly Catholic Mass is on Saturday evening or on Sunday
 - participation in preferred recreational activities – are the activities observed, documented, or mentioned on interview those that the individual is interested in; do they match what is identified in the CFA?
 - take note of opportunities for positive practice – do the staff take advantage of naturally occurring opportunities throughout the day? Examples occur all the time throughout the day, and this is how the goal of active treatment is met. If an individual has a plan to pour a drink, is he pouring the drink at dinner? If he is learning colors (blue and red), do staff ask him to identify the color when he puts on a red shirt in the morning? Recognizing simple but ongoing opportunities for implementation of plans is the key to success in having observable delivery of "active treatment".
 - are staff able to provide examples of these types of opportunities? Have the clinicians ensured staff are able to provide these examples?
 - immediately address situations in which there is evidence that a WTP may no longer be needed because the skill identified as a need is evidenced on observation (i.e. goal to ambulate 25 ft., individual is ambulating independently in excess of 25 ft. on observation; goal to pour drink into a glass, noted to pour soda independently at snack on the unit; goal to identify coins, able to tell you how much money several coins adds up to when asked; etc.)
2. The QMRP note is to be dated and signed
3. The QMRP Review of the IPP is not a restatement of progress notes, but a review of the individual's treatment program, and the overall effectiveness as evidenced on review and observation. The process includes a review of efforts to ensure implementation of treatment, and observation of individuals in different settings. When visiting on the living unit and/or in the program room, ask the staff the following questions:

- What are you doing?
- Why are you doing it? What plan is being reinforced? What is the benefit of participating in this activity?

When staff are be able to state the answers to these questions, and the answer is in agreement with the assessment and treatment information found in the individual's CFA/IPP, there is evidence of effective active treatment

4. The QMRP must visit off site programs/locations (including school programs, voluntary agency programs, etc.) at least once per month and document in the monthly summary that the treatment that is occurring is consistent with the plan(s) discussed in the CFA
5. Document any changes to placement plans as appropriate.

COMMUNITY PLACEMENT PROCESS

The DDSO Community Placement Process (CPP) is a set of clearly defined procedures that describe the process by which individuals living in developmental centers will move to community residential opportunities.

The Treatment Team for each individual being served at Broome Developmental Center will assess the individual's interest in and appropriateness for eventual movement to a community setting at the 30 day review following admission. It will be discussed thereafter at each 90 day review, or more frequently as status changes occur. This review will be accomplished with the participation of the individual, and the family member and/or advocate. This discussion is documented in the review minutes. If community placement is deemed appropriate, referral to the Admission and Placement Committee will be made and documented. All current opportunities to meet the individual's needs and stated preferences will be considered.

As the Treatment Team evaluates an individual's appropriateness for community placement, consideration must be given to specified areas of supports and services. If significant obstacles are currently present (e.g. behavioral, medical, family opposition, or other reasons), specific information is to be included in the related need area outlining how the issue is being addressed. The planning information needs to be reviewed at a minimum, every 90 days. Areas to be addressed include living arrangements, health, financial, day services, social/recreational, family, transportation, religion, behavior, program goals, and placement efforts.

As part of the Community Placement Process, OPPWD has developed the following "readiness" standard to assist DDSO's:

"The individual's clinical team including input from the individual and/or appropriate family/advocate will decide when an individual is appropriate for placement in the community. In making this decision, the team shall consider that an individual is ready when he/she no longer needs the structure, supports and services of the developmental center. This individual would be able to live in the community with reasonable safety to self and others with the supports and services that are available in the community."

Once a specific placement opportunity or plan has been identified, progress towards accomplishing this placement will be reviewed by the Treatment Team at every 90 day review or sooner if opportunities or status changes occur. This information as well as the projected date of placement and the individuals, family members and/or advocates response to the plan will be documented by the team in the meeting minutes.

If the individual, family member and/or advocate have stated a preference for a provider or other aspect of the proposed services, this information is to be considered when developing the individual's community placement plan. Representatives from the prospective provider agency should participate in the development and implementation of the individual's plan, and shall be encouraged to participate in appropriate team meetings including but not limited to 90 day and annual reviews.

If community placement is not indicated at the time of the 30 day, annual or 90 day review, the Treatment Team must identify and document which skills and/or supports are needed prior to community placement being considered. Progress towards addressing these skills and/or supports is documented in the annual and 90 day review until such time as a community placement referral is deemed appropriate.

Once placement is imminent, all appropriate procedures and individual specific required activities, including notifications and right to object procedures, as outlined in the "Green Book" and in Broome P/P 1.2 – Admission/Placement/Discharge Policy and Procedures are to be followed.



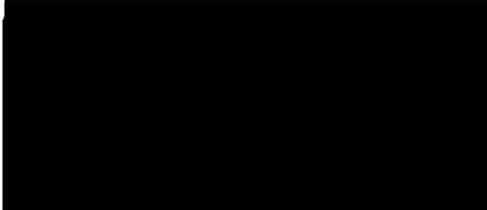


CAS core assessment

- Identification information
- Intake and initial history
- Community and social involvement
- Strengths, relationships and supports
- Lifestyle
- Environmental assessment
- Communication and vision
- Cognition
- Health conditions
- Everyday activities
- Oral and nutritional status
- Mood and Behavior
- Medications
- Services
- Disease diagnosis
- Assessment information

Each section has the ability for the assessor to document additional information in a notes field.

Supplements:

- Child/adolescent
 - Medical Management
 - Forensics
 - Mental Health
 - Substance Use
- 

**OPWDD ARTICLE 16 (Part 679) CLINIC TREATMENT PROGRAM
ACTIVITY RECORDING AND NOTES**

Individual: TABS #:	Location of Service: Article 16 Clinic 6007 Fair Lakes Rd., Suite 400 East Syracuse, NY 13057	Discipline: Psychiatry
ICD-9-CM Code/Treatment Diagnosis:	Staff Name/Title: Dr. Mark E. Slaven, M.D. Psychiatrist II License No. 196469	Staff TABS ID #: 14604

Clinic note must include signature, date and title. (Also, explain in detail therapies or modalities used and status of plan):

DATE [M/D/Y]	CLOCK TIME	Activity Code	Activity Duration Minutes
	Time In		
Location Code: 370	Time Out		

DATE [M/D/Y]	CLOCK TIME	Activity Code	Activity Duration Minutes
	Time In		
Location Code: 370	Time Out		

DATE [M/D/Y]	CLOCK TIME	Activity Code	Activity Duration Minutes
	Time In		
Location Code: 370	Time Out		

DATE [M/D/Y]	CLOCK TIME	Activity Code	Activity Duration Minutes
	Time In		
Location Code: 370	Time Out		

Signature/Title _____

Date _____

Date Entered: _____

Initial: _____

RETURN TO CLINIC: Date: _____

Time: _____

**OPWDD ARTICLE 16 (Part 679) CLINIC TREATMENT PROGRAM
ACTIVITY RECORDING AND NOTES**

Individual: TABS #:	Location of Service:	Discipline:
ICD-9-CM Code/Treatment Diagnosis:	Staff Name/Title:	Staff TABS ID #:

Clinic note must include signature, date and title. (Also, explain in detail therapies or modalities used and status of plan):

DATE [M/D/Y]	CLOCK TIME	Activity Code	Activity Duration Minutes	
	Time In			
Location Code:				
	Time Out			

DATE [M/D/Y]	CLOCK TIME	Activity Code	Activity Duration Minutes	
	Time In			
Location Code:				
	Time Out			

DATE [M/D/Y]	CLOCK TIME	Activity Code	Activity Duration Minutes	
	Time In			
Location Code:				
	Time Out			

DATE [M/D/Y]	CLOCK TIME	Activity Code	Activity Duration Minutes	
	Time In			
Location Code:				
	Time Out			

Signature/Title _____

Date _____

Date Entered: _____

Initial: _____

RETURN TO CLINIC: Date: _____

Time: _____

**OPWDD ARTICLE 16 (Part 679) CLINIC TREATMENT PROGRAM
ACTIVITY RECORDING AND NOTES**

Individual: TABS #:	Location of Service: Article 16 Clinic 6007 Fair Lakes Rd., Suite 400 East Syracuse, NY 13057	Discipline: Psychiatry
ICD-9-CM Code/Treatment Diagnosis:	St [REDACTED] License No. [REDACTED]	Staff TABS ID #: [REDACTED]

Clinic note must include signature, date and title. (Also, explain in detail therapies or modalities used and status of plan):

DATE [M/D/Y]	CLOCK TIME	Activity Code	Activity Duration Minutes
	Time In		
Location Code: 370			
	Time Out		

DATE [M/D/Y]	CLOCK TIME	Activity Code	Activity Duration Minutes
	Time In		
Location Code: 370			
	Time Out		

DATE [M/D/Y]	CLOCK TIME	Activity Code	Activity Duration Minutes
	Time In		
Location Code: 370			
	Time Out		

DATE [M/D/Y]	CLOCK TIME	Activity Code	Activity Duration Minutes
	Time In		
Location Code: 370			
	Time Out		

Signature/Title _____

Date _____

Date Entered: _____

Initial: _____

RETURN TO CLINIC: Date: _____

Time: _____

VERIFICATION/INFORMED CONSENT-PSYCHOTROPIC MEDICATION

A behavioral (psychotropic) medication is defined as "any medication used to influence behavior, thought and/or affect. For example, a drug would not be considered to be a behavioral medication, if it was being used to assist a consumer in going to sleep." (633.16)

All behavioral medications need informed consent on an annual basis. Additionally, informed consent must be obtained prior to the initiation of a medication which is new to that person's regimen.

When a psychotropic medication is added to a consumer's regimen, or when the medication dosage is above the range for which initial informed consent was given, informed consent must again be sought.

Additionally, according to the OMRDD Medication Curriculum (2001), any new medication orders must be verified by the RN/RN-On-Call before the medication is administered to the consumer.

SCENARIO #1-Annual consent for psychotropic medication is needed. The psychologist will initiate process for these consents. RN and/or psychologist will review medication regimen per team process.

SCENARIO #2-Staff return to residence with new psychotropic prescription for a consumer. Prior to the administration of the new medication, verification of the medication and informed consent must be obtained. Staff must contact both the RN/RN-On-Call and psychologist per team process.

The RN will verify the addition of the medication, checking for dosage, allergies, interactions, side effects of the medication, as well as establishing a schedule for administration of the med.

AND ALSO PRIOR TO ADMINISTRATION OF THE PSYCHOTROPIC:

The psychologist will obtain informed consent for the new medication. This process will involve contacting person(s) designated in the consumer's ISP listed as able to provide the consent.

SCENARIO #3-In the event that emergency approval is being sought, RN or RN-on-call will verify the medication and informed consent will be obtained per emergency approval policy guidelines.

FOR INFORMATION ON USE OF ORAL PRN PSYCHOTROPICS, SEE PROTOCOL.

FOR INFORMATION ON USE OF PRESEDATION, SEE PRESEDATION POLICY

**CLINICAL COMPETENCY: Tracheostomy Care For a Single Cannula
PART I**

The RN/LPN noted below has completed training in the tracheostomy curriculum and must now demonstrate clinical competency.

INSTRUCTIONS

The supervising RN at the residence or day program will evaluate this task for one or more consumers at the site, at the discretion of the RN.

All items must be checked YES, NO or N/A for attainment of the competency.

All attempts at attainment are to be documented.

	YES	N/A	NO
1. At the beginning of the shift, checks practitioner order for frequency of tracheostomy care			
2. Gathers necessary equipment for trach. care According to CNY-DSO protocol			
3. Explains all procedures to the consumer and provides privacy.			
4. Observes: Skin condition at the stoma site and tracheal secretions (color, amount, consistency, odor)			
5. Washes hands			
6. Suction if necessary			
7. Washes hands			
8. Open sterile 4X4's and wet some with hydrogen peroxide and some with sterile water (or do the same with sterile cotton tipped applicators)			
9. Put on gloves			
10. Use 4x4's/cotton applicators soaked in hydrogen peroxide to clean the stoma area and then rinse with sterile water using sterile gauze/applicators. Pat dry with sterile gauze 4x4.			
11. Change tube holder or ties with assistance of another person at least q 24 hours and prn			
12. Discard gloves			
13. Wash hands			
14. Documentation according to site's protocol			

NAME	SS # (last 4 digits)	TITLE
------	----------------------	-------

RN EVALUATOR	SITE	DATE
--------------	------	------

**CLINICAL COMPETENCY: Tracheostomy Care for Inner Cannula
PART II**

The RN/LPN noted below has completed training in the tracheostomy curriculum and must now demonstrate clinical competency.

INSTRUCTIONS

The supervising RN at the residence or day program will evaluate this task for one or more consumers at the site, at the discretion of the RN.

All items must be checked YES, NO or N/A for attainment of the competency.

All attempts at attainment are to be documented.

	YES	N/A	NO
<ol style="list-style-type: none"> 1. Obtain equipment needed 2. Suction if necessary 3. Washes hands 4. Put on non-sterile gloves, open trach. kit and pour hydrogen peroxide in one container and sterile water in the other container 5. Place inner cannula in hydrogen peroxide container and soak 6. Remove and dispose of old dressings from tracheostomy site 7. Assess skin condition around tracheostomy site for redness, inflammation, lesions, drainage 8. Remove and dispose gloves 9. Wash hands 10. Place sterile gloves found in trach. kit 11. Using sterile Q-tip applicator or 4X4's, clean trach. site with hydrogen peroxide. With remaining applicators/4x4's rinse with sterile water. Clean inner cannula with sterile brush provided 12. Rinse cannula with sterile water, shake off excess water 13. Using the unused pipe cleaners, dry the inside of the inner cannula tube 14. Reinsert the inner cannula and lock in place 15. Replace the tracheostomy holders q 24 h and prn with the assistance of another person 16. Apply clean tracheostomy dressing 17. Discard gloves and other disposables 18. Washes hands 19. Document according to site's protocol 			

NAME	SS # (last 4 digits)	TITLE
------	----------------------	-------

RN EVALUATOR	SITE	DATE
--------------	------	------

Topical Health Products

The following topical applications may be applied by any direct care staff, with approval by the supervising RN. They do not require an MD order and are not documented on the MAR.

Moisturizing creams and lotions		
	To prevent dry or irritated skin	Precautions
Eucerine Cream Keri Lotion/Sarna Lotion Lubricants	Apply to dry and irritated skin areas	Notify RN if unexpected redness occurs
Barrier Creams		
	To Prevent red skin and skin breakdown	Precautions
Balmax Sween Cream A&D Ointment Bag Balm Desitin Ointment	Apply to risk areas of the skin	Notify RN if unexpected redness, irritation or skin breakdown occurs
Sun Barriers		
	To Prevent sunburn	Precautions
Sunscreen	Apply to exposed areas of skin	Notify RN if redness or rash occurs
Ointments, lotions and creams		
	To prevent minor itching / insect bites	Precautions
Calamine Lotion	Apply to minor skin irritation or insect bites	Notify RN if unexpected swelling, pus, or redness, occurs
Cutter / Off insect repellants	Follow product directions	
Shampoos		
	To prevent dry scalp and dandruff	Precautions
Dandruff Shampoo Zincon Shampoo Tegrin/Selsun Blue	Apply to scalp when washing hair	Notify RN if red scalp, and/or unexpected flaking occurs
Lip Balms		
	To prevent dry or cracking lips	Precautions
Blistex	Apply to lips	Notify RN if sores on lips or swelling of lips occur

- ▶ These products may be applied by direct staff who are not AMAPs (Med certified)
- ▶ Staff must read and follow all directions, including dosage, use, and contraindications concerning these products
- ▶ Health Care Products must be stored safely in a designated area. They do not need to be stored in the medication cabinet
- ▶ Generic substitutes of these products may be used as approved by the supervising RN
- ▶ Documentation of the use of these products may be done at the RN's discretion
- ▶ Ointments, lotions, creams and medicated shampoos should be stored in individual specific containers or applied from a stock bottle with a new applicator for each dose (e.g., tongue depressor, medicine cup, etc.) as approved by the supervising RN
- ▶ If the health product should be monitored more closely, then an Health Care Provider (HCP) order should be obtained

TELEPHONE ORDER

Telephone orders may be accepted by an AMAP only when an R.N. or L.P.N. is not available and a fax of the order is not possible. The telephone order should be documented on this form, consultation sheet, or health care provider order sheet and filed in the consumer's chart. All new or changed orders must be verified by an RN/RN-On-Call prior to administration.

When taking a verbal or telephone order, ask the health care provider to spell the name of the drug, specify what the medication is for and state the specifics of administration.

Consumer's name:

Date/time:

Medication name:

Dose:

Route:

Frequency:

Form:

Start date:

Stop Date:

Additional instructions:

Practitioner name:

Staff Signature:

If this is a new order, transcribe the telephone order on to the MAR and complete a Specific Medication Information Sheet.

If this is a change of a current medication order, DO NOT ALTER THE MEDICATION LABEL. "Flag" a medication change by placing a sticker or securing a note to the medication label designating the medication change along with the date and your initials. Fill out the "change" section of the current Specific Medication Information Sheet.



CONFIDENTIAL

Team Evaluation Report

Child's Name: Gender: Male
Date of Birth:
Date of Evaluation:
Chronological Age:
Date of Team Conference:
Date of Family Conference:
Mother:
Address:
Home Phone: ; Cell:
Email Address:
Primary Care Physician:
Case Manager:
ICD9 Code: (number only)

Team Members:

██████████, MA, CAS, School Psychologist
██████████, N.P., M.S.R.N., Family Psychiatric Nurse Practitioner
██████████, M.D., Pediatrician
██████████, Ph.D., Licensed Psychologist
██████████, Ph.D., School Psychologist/Special Education
██████████, M.D., Child & Adolescent Psychiatrist
██████████, PT, DPT, Physical Therapist
██████████, M.S., CCC-SLP, Speech Language Pathologist
██████████, MS, OTR/L, Occupational Therapist
██████████, M.S., SpecEd/ElemEd
██████████, Ph.D., Licensed Psychologist
██████████, M.S., CCC-SLP, Lic., Speech Pathologist
██████████, Ph.D., Licensed Psychologist
██████████, M.D., Pediatrician
██████████, M.S., CCC-SLP, Lic., Speech Pathologist
██████████, M.S., CCC-SLP, Lic., Speech Pathologist
██████████, M.D., Pediatrician
██████████, M.S., Psychologist
██████████, OTR/L, Occupational Therapist
██████████, OTR/L, Occupational Therapist
██████████, MEd., CCC-SLP, Lic., Speech Pathologist
██████████, OTR/L, Occupational Therapist
██████████, Psy.D., School Psychologist
██████████, M.S., School Psychologist

CHILD'S NAME
DOB:

TEAM EVALUATION REPORT
DOE:

is a year month-old boy who was referred to the Developmental Evaluation Center (DEC) for concerns regarding learning and behaviors. was seen at the DEC on, and a family conference was held immediately following the assessment. The child was at the center for hours, with a one-hour lunch break over the noon-hour.

At that time, the impressions and recommendations of the developmental specialists could be summarized as follows.

Background and Social History: (, M.D., Pediatrician)

Medical History:

Medical information as reported by the child's parent, other providers and previous evaluations, is as follows.

was the lb. oz., -week, for gestational age baby born to a healthy year-old, gravida mother. Pregnancy was not complicated by medications, drugs, alcohol or unusual exposures. Labor was spontaneous and delivery was , with Apgar scores of .

Past medical history shows that has always been relatively healthy. has had no hospitalizations or serious illnesses. is on no medications and major allergies have not been identified. Immunizations are up to date. Home safety and accident prevention have been discussed previously and were reiterated at today's DEC evaluation.

The child has not had a history of, nor currently is experiencing chronic pain issues that have interfered with developmental milestones or activities of daily living.

Hearing has been assessed, and is normal.

Family Background Information:

Parental Report of Developmental History & Concerns:

The family was interviewed regarding their priorities, needs and concerns. The parents would like help with No other needs were identified by the family.

Educational Information:

Educational history was gathered from the parents, available records, and other providers.

CHILD'S NAME
DOB:

TEAM EVALUATION REPORT
DOE:

Transdisciplinary Assessment Procedures:

- Review of records
- Parental interview
- Observation of child in natural setting
- Observations of free play & assessment by transdisciplinary team
- Informal play-based assessment procedures
- Discipline Assessments:
 - Psychology:
 - Wechsler Preschool & Primary Scale of Intelligence - Fourth Edition (WPPSI-IV)
 - Vineland Adaptive Behavior Scales, Second Edition (Vineland-II)
 - Conners Early Childhood (Conners EC)
 - Speech/Language Pathology:
 - Occupational Therapy:
 - Physical Therapy:
 - Physical Examination

Transdisciplinary Assessments:

Transdisciplinary behavior observation

The family reported that the behaviors observed were typical of daily performance, thus the results are believed to be a valid representation of the child's abilities.

The parents participated in the evaluation process, either within the evaluation room or from behind a two-way mirror (observing and providing information).

Psychological Assessment: ([REDACTED] Ph. D.)([REDACTED] Ph.D.)
([REDACTED] MA, CAS, NCSP)
([REDACTED] Ph.D.)([REDACTED] Ph.D.)
[REDACTED] M.S.) ([REDACTED] Psy.D.)

Speech/Language Assessment: ([REDACTED] M.S., CCC-SLP, Lic.) ([REDACTED]
[REDACTED] MEd., CCC-SLP, Lic.) ([REDACTED] M.S., CCC-SLP, Lic.) ([REDACTED]
[REDACTED] M.S., CCC-SLP, Lic.) ([REDACTED] M.S., CCC-SLP, Lic.)

CHILD'S NAME
DOB:

TEAM EVALUATION REPORT
DOE:

Motor Assessment: ([REDACTED] OTR/L) ([REDACTED] OTR/L) ([REDACTED] OTR/L) ([REDACTED] OTR/L) ([REDACTED] PT, DPT)

Pediatric Physical Examination: ([REDACTED] M.D., Pediatrician) ([REDACTED] M.D., Pediatrician) ([REDACTED] M.D. Pediatrician)

Weight was lbs., which is at the percentile. Height was inches, which is less than the percentile. Head circumference was cm., which is at the percentile.

Skin was clear. Examination of the HEENT revealed a non-dysmorphic with a normal skull and normal hair distribution. Extraocular movements were normal. The ear canals and tympanic membranes were benign. Nose was clear. Mouth did not reveal excessive drooling. Gag reflex was intact. The buccal mucosa, hard and soft palate, and teeth were normal. Neck was supple without masses. Back was smooth without deformity. Lungs were clear. Heart was regular with no murmurs. Abdomen was soft without hepatosplenomegaly or masses. Musculoskeletal system showed normal tone.

Neurological examination revealed a symmetrical

Muscle strength was normal, as was sensation. Examination of the cranial nerves was grossly normal, but hearing and vision were not objectively assessed. Balance was intact. Reflexes were 1+ and symmetrical.

Gross motor function showed ascended and descended stairs Fine motor abilities showed that

Medical Impression:

Diagnostically, no further diagnostic pediatric developmental laboratory testing is recommended at this time.

Developmental Impression:

ICD: 9 Code: INSERT APPROPRIATE CODE

Recommendations: (Education and Medical. Must match eligibility statement)

While no DEC follow-up is scheduled at this time, the family is encouraged to contact the DEC if additional questions or concerns arise.

CHILD'S NAME
DOB:

TEAM EVALUATION REPORT
DOE:

Please note: Although this evaluation report contains recommendations regarding services for your child, they are provided solely for consideration and discussion by the entire CPSE of which you, the parent, are a member. It is only at the CPSE meeting that final Individual Education Program recommendations for your child are fully determined.

Suggested Intervention Strategies & Resources:

It was a pleasure working with and her family. We wish them the best.

MA, CAS
School Psychologist
Licensed Mental Health Counselor

N.P., M.S.R.N.
Family Psychiatric Nurse Practitioner

M.D.
Pediatrician

Ph.D.
Licensed Psychologist

Ph.D.
School Psychologist/ Special Education
Licensed Mental Health Counselor

M.D.

CHILD'S NAME
DOB:

TEAM EVALUATION REPORT
DOE:

Child & Adolescent Psychiatrist

██████████ PT, DPT
Physical Therapist

██████████ M.S., CCC-SLP, Lic.
Speech Pathologist

██████████ OTD, MSOTR/L
Occupational Therapist

██████████ M.S., SpEd/ElemEd
Special Education Teacher
Elementary Education Teacher

██████████ M.S., CCC-SLP, Lic.
Speech Pathologist

██████████ Ph.D.
Licensed Psychologist

██████████ MD
Pediatrician

██████████ M.S., CCC-SLP, Lic.
Speech Pathologist

CHILD'S NAME
DOB:

TEAM EVALUATION REPORT
DOE:

██████████ M.S., CCC-SLP, Lic.
Speech Pathologist

██████████ M.D.
Pediatrician

██████████ M.S.
Psychologist

██████████ OTR/L
Occupational Therapist

██████████ OTR/L
Occupational Therapist

██████████ MS Ed, CCC-SLP, Lic.
Speech Pathologist

██████████ OTR/L
Occupational Therapist

██████████ Psy.D.
School Psychologist

CHILD'S NAME
DOB:

TEAM EVALUATION REPORT
DOE:

Addendum:

Immediately following the completion of this assessment, a family conference was held with..... The results of the evaluation and recommendations were discussed.

Report sent to:
Parents:
CC:

CNYDSO Policy 1.1.6.3: Under normal circumstances Approved Medication Administration Personnel (AMAP) may administer medication after receiving appropriate training and clinical certification. However, there may be times when Approved Medication Administration Personnel medication certification may be temporarily suspended at the discretion of the Supervising Registered Nurse.

AMAP Name: _____

Location: _____ **Date:** _____

REASON FOR AMAP TEMPORARY SUSPENSION

1. Medication Administration Errors	
Medication error that caused adverse reactions.....	<input type="checkbox"/>
Multiple medication errors	<input type="checkbox"/>
Non-compliance with medication policy and procedure..	<input type="checkbox"/>
2. Other	<input type="checkbox"/>
3. Comments:	

REMEDIAL PLAN

1. On site training....	<input type="checkbox"/>	3. Clinical Competency Review (Successful Practicum)	<input type="checkbox"/>
2. Self-Study.....	<input type="checkbox"/>	4. Remedial training (referred to Staff Development)	<input type="checkbox"/>
Comments:			

NOTIFICATIONS:

AMAP Name:	Verbal notification Date:	Written notification date:
AMAP Supervisor Name:	Notification Date	Method of Notification
Team Leader Name:	Notification Date	Method of Notification
Nursing Program Coordinator Name:	Notification Date	Method of Notification
Staff Development Medication Training Coordinator :	Notification Date	Method of Notification

AMAP suspension remains in effect until _____ or until all remedial objectives are met.
(Date)

Referred to Human Resources for multiple suspensions or health concerns:

Yes No

Signature of AMAP: _____ **Date:** _____

Signature of RN: _____ **Date:** _____

Topic:
Hours: 0.5 hr.

CLINICAL COMPETENCY: SUPRA-PUBIC CATHETER TUBE REPLACEMENT

The RN/LPN noted below has completed training in the Supra-Pubic Catheter Replacement and must now demonstrate clinical competency.

INSTRUCTIONS

The supervising RN at the residence or day program will evaluate this task. The instructor must be an RN. The responsibility of the RN will be to determine the appropriate RN/LPN to perform this task. The LPN will also be in agreement to take on the responsibilities in this role.

All items must be checked YES, NO or N/A for attainment of the competency.

All attempts at attainment are to be documented.

	YES	N/A	NO
1. Checks prescribers orders			
2. Positions the consumer on his/her back with SPC insertion site exposed.			
3. Thoroughly washes hands.			
4. Uses sterile technique and opens out the catheter pack and add new catheter, two syringes, cleaning solution, sterile normal saline and some lubricant to the sterile field.			
5. Opens both glove packets.			
6. Wash hands thoroughly for at least 3-5 minutes.			
7. Uses sterile technique in applying both pairs of gloves (one on top of the other).			
8. Cleans around catheter site thoroughly using cleaning solution.			

INSTRUCTIONS

The supervising RN at the residence or day program will evaluate this task for one or more consumers at the site, at the discretion of the RN.

All items must be checked YES, NO or N/A for attainment of the competency.

All attempts at attainment are to be documented.

	YES	N/A	NO
9. Using one syringe deflate balloon and remove catheter (you may feel some mild resistance). Notes how far in the catheter is. Opens replacement tube package			
10. Removes top gloves (leaving the 2 nd sterile pair on).			
11. Pick ups the pre-lubricated catheter and inserts only as far in as the previous catheter was (inserting too far may go into the urethra).			
12. Watches for urine to flow from the catheter (may take a few minutes if a routine catheter change).			
13. Once urine is draining from the catheter the balloon is inflated using 5-8mls of sterile water or per prescribers order.			
14. Attaches a drainage bag.			

15. Gently guide lubricated tube through stoma and into stomach (aprox. 1-1-1/2 inch on children and 2-4 inches on adults). Be cognizant of adipose tissue and position of balloon in relation to tip of tube.

Replacement tubes should easily advance through the stoma/tract into the stomach. If resistance, bleeding or any difficulty is encountered, stop the procedure and notifies the health care provider.

16. Inflates the balloon while holding tube in place.

17. Withdraws the tube until slight tension is felt from the balloon coming up against the stomach wall.

18. Slides external bumper/disc, secure-lok or baby bottle nipple down toward stoma to maintain tension. Does not apply excessive tension.

19. Leaves stoma open to the air. Cleanses stoma site with mild soap and water QD and prn, pat site completely dry. If site becomes reddened, inflamed, excoriated or has excessive drainage, consults health care provider for treatment.

20. Verifies tube placement and patency:

- aspirates and note amount and type of aspirate. Returns aspirate to stomach unless there is an excessive amount or other concern.
- Instills small amount of air (aprox. 5cc) and listens for air entering stomach with stethoscope.

21. Documentation should include:

Date/time, replaced tube size and type, amount of balloon inflation, stoma assessment, description of aspirate, placement and patency check, reason for replacement, how the consumer tolerated the procedure, any complications, full signature and title of the nurse.

NAME

SS # (last 4 digits)

TITLE

RN EVALUATOR

SITE

DATE

Name (Last, First, M.I.)								"C" No./DDIS Number					Date of Birth			Gender			
YEAR:		D - Day (7 AM - 3 PM) E - Evening (3 PM - 11 PM) N - Night (11 PM - 7 AM)					Total No. of Seizures Each Jan. - June					G - Generalized (Grand Mal) A - Absence (Petit Mal) P - Psychomotor, Jacksonian, etc.							
J A N U A R Y		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	Sub Total		
	D																		
	E																		
	N																		
		16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Total	
	D																		
E																			
N																			
F E B R U A R Y		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	Sub Total		
	D																		
	E																		
	N																		
		16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Total	
	D																		
E																			
N																			
M A R C H		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	Sub Total		
	D																		
	E																		
	N																		
		16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Total	
	D																		
E																			
N																			
A P R I L		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	Sub Total		
	D																		
	E																		
	N																		
		16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Total	
	D																		
E																			
N																			
M A Y		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	Sub Total		
	D																		
	E																		
	N																		
		16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Total	
	D																		
E																			
N																			
J U N E		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	Sub Total		
	D																		
	E																		
	N																		
		16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Total	
	D																		
E																			
N																			

State of New York
OFFICE OF MENTAL RETARDATION AND
DEVELOPMENTAL DISABILITIES

Form 216 MED (MR) (9-82)

SEIZURE CHART

Facility/Agency

EACH OCCURRENCE MUST BE DESCRIBED FULLY IN CLIENT'S NOTES.

Name (Last, First, M.I.)								"C" No./DDIS Number				Date of Birth				Gender			
YEAR:		D - Day (7 AM - 3 PM) E - Evening (3 PM - 11 PM) N - Night (11 PM - 7 AM)						Total No. of Seizures Each July - Dec.						G - Generalized (Grand Mal) A - Absence (Petit Mal) P - Psychomotor, Jacksonian, etc.					
J U L Y		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	Sub Total		
	D																		
	E																		
	N																		
		16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31		Total
	D																		
	E																		
A U G U S T		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	Sub Total		
	D																		
	E																		
	N																		
		16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31		Total
	D																		
	E																		
S E P T E M B E R		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	Sub Total		
	D																		
	E																		
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		16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31		Total
	D																		
	E																		
O C T O B E R		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	Sub Total		
	D																		
	E																		
	N																		
		16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31		Total
	D																		
	E																		
N O V E M B E R		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	Sub Total		
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		16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31		Total
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	E																		
D E C E M B E R		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	Sub Total		
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		16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31		Total
	D																		
	E																		

State of New York
OFFICE OF MENTAL RETARDATION AND
DEVELOPMENTAL DISABILITIES

SEIZURE CHART

EACH OCCURRENCE MUST BE DESCRIBED FULLY IN CLIENT'S NOTES.

OPWDD State Operations Office, Region 2

Article 16 Clinic

Article 16 Clinic at Broome
 305 Main Street
 Binghamton, NY 13905
 Phone: (607) 729-1295
 Fax: (607) 777-9497

Article 16 Clinic at Fairlakes
 6007 Fair Lakes Rd., Suite 400
 E. Syracuse, NY 13057
 Phone: (315) 473-2957
 Fax: (315) 234-5745

Article 16 Clinic at Rome
 200 W. Dominick Street
 Rome, NY 13440
 Phone: (315) 339-6536
 Fax: (315) 281-0080

Article 16 Clinic Consumer Satisfaction Survey

Your feedback regarding the provision of OPWDD Region 2 Article 16 service is important to us and we are asking you to complete the enclosed survey. If you live in a certified setting, your staff or family care provider can assist you. If you live at home, a family member can assist you. Please return this form to the appropriate clinic address as noted above. If you have any questions or would like to discuss any issues related to Article 16 Clinic Services, please feel free to contact your clinic treatment coordinator at the appropriate clinic.

Individual's Name:		Date sent:	
Completed by (optional): (Name/relationship)		Date completed:	

Service:	Clinic Provider:
----------	------------------

1. Are you involved in planning and delivery of your treatment?
 - a. How often do you see this clinician?
 - b. What do you and the clinician work on?
 - c. Is this service helpful? Yes/No
 - d. Does the clinician listen to your ideas, questions, or concerns? Yes/No
 Please explain and give examples. How could this improve?

2. Describe your interactions with your clinician.
 - a. Are your interactions with the clinician helpful? Yes/No
 - b. Are your interactions with the clinician respectful? Yes/No
 - c. Are your interactions with the clinician courteous? Yes/No
 Please explain and give examples. How could this improve?

3. Are all of your goals related to this service being met?
 - a. Are there areas or goals you want to work on? Yes/No
 - b. What are the areas or goals you want to work on?

4. Any additional comments?

OPWDD State Operations Office, Region 2
Article 16 Clinic at Rome
200 W. Dominick St.
Rome, New York 13440
(315) 339-6536

--	--

(Name of MSC or individual's contact person)

(Date)

--	--

(Name of Individual)

(TABS#)

A review of this individual's record shows that the following documentation is missing from the record. As a reminder, these items are "elements of participation" for Article 16 services. We are a Medicaid funded program and therefore have specific guidelines we must follow. Your ongoing efforts in supplying these allow for the continuity of services for the individuals we serve and will avoid unnecessary un-authorization while we obtain these forms from you. Please call with any questions. I will be happy to assist you.

- ___ Individualized Service Plan (copy)
- ___ Safeguards/Individual Plan for Protective Oversight (copy)
- ___ Current Behavior Plan (copy)
- ___ Primary Care Physician's Referral
- ___ Annual Physical Exam
- ___ Proof of Negative PPD test or Letter of Exemption from PCP
- ___ Receipt of Bill of Rights- signed
- ___ Privacy Practices Receipt- signed (9/13)
- ___ Client Needs Assessment Form (DDP4) (copy)
- ___ Client Developmental Disabilities Profile (DDP2) copy of *current* DDP2
- ___ Insurance Information (copy of insurance cards)
- ___ Other:

___ Also, please note that you will find attached, a copy of the most recent treatment plans/semi-annual or annual review(s) for the above named individual. Please review the information and place it in the individual's record.

<u>Name of Clinic Treatment Coordinator (CTC):</u> [REDACTED]	RN2
<u>CTC phone #:</u> (315)339-6536 x3162	Article 16 Clinic at Rome 200 W. Dominick Street Rome, New York 13440

Regards,

--

(Clinic Treatment Coordinator's Signature/Title/Date)

RESPIRATORY CHECKLIST

Complete the following steps every 4 hours for the first 48 hours and then every 8 hours until well.

Name _____

◆Enter Date ⇨							
◆Enter time ⇨							
◆Enter your initials ⇨							
◆Check temperature and record ⇨ →Call RN if temperature is above or below consumers normal range (_____ to _____) →If fever med is given (per RN), repeat temp after 1 hour & call RN if temperature is still elevated							
◆Check pulse and record ⇨ →Call RN if pulse is < 60 or > 120							
◆Check respirations and record ⇨ →Call RN if respirations are < 14 or > 24 →Call 911 if there is difficulty breathing (is breathing hard, in a strange way or needs to sit up or lean forward to breathe)							
◆Check blood pressure and record ⇨ →Call RN if systolic pressure (top #) is < 90 or > 160							
◆Monitor cough and record ⇨ (Enter "no" cough, "occasional" cough, or "frequent" cough) →Call RN if cough interferes with breathing, eating, drinking or sleeping							
◆Monitor sputum (cough discharge) & record ⇨ (Enter "none", "occasional" or "frequent" / "clear", "white", "yellow", "red", "brown", or "green")							
◆Check oximetry , if available, & record ⇨ →Call RN if oximetry is below 91							
◆Monitor color and record ⇨ (Enter "Normal" - skin color is normal for this person, or "Flushed" - redness of face or skin, or "Pale" - loss of color in face or skin, or "Cyanotic" - bluish/greyish color to lips, face or skin) →Call RN if flushed, pale, or cyanotic							
◆Monitor mental Status and record ⇨ (Enter 'Normal' - normal for this person, or "Irritable" - excessive reponse or excitability or "lethargic" - very drowsy & groggy but can wake up or "disorientated" = unusually confused) →Call RN if unusually irritable or lethargic →Call 911 if uresponsive or unusually confused							
◆Encourage fluids and record intake ⇨ (Enter "Drinking fluids", or "sipping fluids", or "refusing fluids") →Call RN if drinking less fluid than normal or the consumer has vomited →Call 911 if refusing all fluids							
◆Monitor urine and record urine output ⇨ Enter 'urinated' or 'no urination' →Call RN if consumer does not void (urinate) during an 8 hour shift.							

PROTOCOL FOR RESPIRATORY INFECTIONS REQUIRING
ANTIBIOTICS

1. RISK ASSESSMENT

The RN will identify consumers who are at a higher risk of developing pneumonia respiratory infections requiring antibiotics. If a consumer is found to be at such risk, this information will be included in the POPO/Nursing Assessment.

The following are factors that have been found to increase the susceptibility to and risk of developing pneumonia. This list is intended as a starting point and is not intended to be exhaustive.

- Age greater than 50 and age extremes (very young, very old).
- Egg allergy (therefore no flu shot).
- Down syndrome with protruding or large tongue.
- History or presence of a swallowing disorder or aspiration.
- Chronic lung disease.
- Previous pneumonia(s).
- Recent hospitalizations.
- Immunosuppression (AIDS, chemotherapy).
- Co-morbid conditions such as (but limited to): congestive heart failure, cardiovascular disease, CVA, renal failure, asplenia (absence of the spleen) diabetes mellitus, malignancy, malnutrition.

2. CRITERIA FOR AT HOME TREATMENT OF RESPIRATORY INFECTIONS - INCLUDING PNEUMONIAS - WHICH REQUIRE ANTIBIOTICS

The consumer must be able to take oral medications (with the exception of those consumers who have g- or j-tubes.)

No severe vital sign abnormality exists. This means:

- Pulse should be 60-135/minute
- Systolic BP should be 90mmHg or higher
- Respirations should be 10-25
- No wide temperature variations above/below the consumer's baseline

There should be no acute mental status changes.

Oximetry should be at 91 or above.

Be aware of other acute medical conditions.

Know your consumers' baseline health status.

3. RESPIRATORY INFECTION-INCLUDING PNEUMONIA-REQUIRING ANTIBIOTICS

When a primary care provider or Emergency Department provider diagnoses a consumer with a respiratory infection requiring antibiotics and they have determined the illness can be treated at home, the following will occur:

LPN/RESIDENTIAL STAFF/LEAD WORKER

- Immediately notify the residential or on call RN.
- Follow-up with primary care provider as directed.
- Implement respiratory reporting checklist
- Verify oximeter is present. If unavailable implement all other components and obtain as soon as possible.

RESIDENTIAL RN

- Review criteria for at-home treatment of respiratory infections requiring antibiotics.
- Notify primary care provider or DSO medical staff if necessary or if the consumer does not meet at-home criteria.
- Review treatment plan with staff.
- Verify oximeter is present and in working order. If unavailable implement all other components of the protocol and obtain oximeter ASAP.
- If the consumer has a roommate discuss the roommate's risk with the staff including measures to reduce the risks including handwashing and temporarily moving the roommate.
- Communicate any abnormal or unexpected events or concerns to the primary care provider.
- Assess consumer and determine when vital signs and oximetry may be discontinued.
- Determine when the consumer may return to program/work in consultation with health care provider.
- Obtain a return-to-work slip PRN.
- Daily site visit or phone contact by residential RN until consumer is determined well. (Residential staff to contact on-call RN on weekends and holidays.)

TREATMENT PLAN FOR RESPIRATORY INFECTIONS

PART I

1. Take vital signs including TPR and BP every four hours (q4h) for first 48 hours, then every eight hours until well ("well" will be determined by an RN). Document this information on Respiratory Infection Reporting Checklist and call as directed.
2. Observe respiratory status every four hours (q4h) for the first 48 hours and then every eight hours until well. Observe quality and rate of respirations, observe for respiratory difficulty - labored breathing, poor color or cyanosis, document on Respiratory Reporting Checklist and call as directed.
3. Perform Oximetry when available (q4h) for the first 48 hours and then every eight hours (q8h) until well ("well" will be determined by a RN), document on Respiratory Reporting Checklist and call as directed.
4. Observe mental status every four hours (q4h) for the first 48

hours and then every eight hours until well. Check for confusion, irritability, panic, disorientation, all of which can be caused by hypoxia (low oxygen in the blood and brain), document on Respiratory Infection Reporting Checklist and call as directed.

5. Monitor I&O - Encourage additional fluids. Observe refusal to drink, vomiting, lack of urination and call as directed.

6. Provide opportunities for rest to conserve energy and decrease oxygen demand.

7. Administer prescribed antibiotic and insure ingestion.

8. Use universal precautions.

9. Dress person appropriately and guard against chilling or overheating.

10. Discuss roommates' at risk with team members.

11. Elevate head of bed as needed.

12. The consumer is to remain home until the residential RN/MD determines when it is appropriate to return to program/work. (Is a return to work slip required?)

PART II

THE FOLLOWING ARE CAUSES FOR CONCERN AND/OR IMMEDIATE ACTION:

The consumer becomes unable to take medication.

A severe vital sign abnormality exists:

- Pulse less than 60 or greater than 120
- Systolic blood pressure below 90
- Respirations above 24 or less than 14
- Acute mental status changes

Oximetry falling steadily or drops below 91.

Fever increasing or remaining elevated after two to three days on antibiotics.

If any of the above events occur, call the RN for further direction.

As always, should any events occur that cause concern for the consumer's well-being, follow the on-call protocol for your county or administrative unit.

Child's Name:

DOB:

Family of Residence:

Mother

Name:

Name at time of child's birth:

DOB:

Occupation:

Employer:

Work Phone:

Father

Name:

DOB:

Occupation

Employer

Work Phone:

Other Adults in Household:

Name Relationship Age

Other Children in Household:

Name Relationship DOB Developmental Concerns

**OPWDD REGION 2
CNY DDSOO- ARTICLE 16 CLINIC**

QUALITY ASSURANCE REVIEW

INDIVIDUAL: _____ TABS # _____ DATE OF REVIEW _____

Current Services (enter corresponding numbers from below): _____

1. **Psychiatry**; 2. **Psychology**; 3. **Audiology**; 4. **Physical Therapy**; 5. **Occupational Therapy**;
6. **Nutrition**; 7. **Speech**; 8. **Other** _____

PART 1

	YES	NO
1. Is Bill of Rights <i>signature receipt</i> present? (Section 1; last page)		
2. Is there proof of 1 TB test or an exclusionary Statement from Primary Physician? (Section 4)		
3. Is the <i>ISP</i> current- dated within 14 months? (Section 1) Date of last ISP _____ (mm/dd/yy)		
4. Are each of the current services listed above also listed in the <i>ISP</i> or on an <i>ISP Addendum</i> (including a <i>6-month ISP Review</i>) as an Article 16 Clinic service? (Section 1)		
5. Is there documentation of eligibility for clinical services? (Section 4; e.g. <i>Eligibility Determination form, Notice of Decision</i> , a document with Diagnosis signed by Physician or PhD, etc.)		
6. Are the initial assessments completed within 30 days of medical director's approval for service? (Section 3; look at <i>Physicians Approval Form</i> date signed by Medical Director and <i>Assessment Findings</i> date of evaluation)		

Comments: _____

PART 2: Ongoing Clinical Services

For Part 2, under each service, fill in the boxes using this key: Y = Yes, N=No, N/A = not applicable

	Corresponding #s			
1. For each clinic service, is there an <i>Ongoing Service Plan</i> signed by the physician? (Section 2)				
2. Is there documentation to support diagnosis for ongoing service? (Section 2; <i>Ongoing Service Plan</i>)				
3. A) Are <i>Activity Recording and Notes</i> forms present for services provided? (Section 5)				
B) Do the <i>Activity Recording</i> notes (Section 5) correspond with the frequency of the <i>Ongoing Service Plan</i> ? (Section 2) (For example, if recommended frequency is q 6 months, there should be a corresponding <i>Activity Recording and Notes</i> form q 6 months.				
C) Is clinician's signature complete [full signature, title, and three-part date (mm/dd/yy) on each <i>Activity Recording and Notes</i> form]? (Section 5)				
4. For each Clinic Service*, does the most recent progress note reflect the stated goals/objectives as noted on the <i>Ongoing Service Plan (Treatment Plan)</i> ? (Section 2)				

Comments: _____

*Note: For questions 4 and 5, Psychiatric services are reviewed with each progress note. Due to changes in procedures, there may not be Annual and 6-month Reviews for psychiatry in the charts prior to 2014. Use N/A to indicate not available.

**OPWDD REGION 2
CNY DDSOO- ARTICLE 16 CLINIC**

		Corresponding #s			
5.	A) For each clinic service*, are <i>Clinic Reviews</i> present every 6 months? (Section 6) [There will be up to 2 years of reviews, 4 documents/service].				
	B) Is each <i>Clinic Review</i> signed by the clinician and treatment coordinator? (Section 6)				
	C) Is each ANNUAL <i>Clinic Review</i> signed by the Medical Director? (Section 6)				
	D) For each clinic service, is the date of the Medical Director's signature within one year and 31 days of the signature on the previous annual review? (Section 6)				

Comments: _____

Reviewer Signature

Date

CORRECTIONS:

- **No Corrections Needed**
- **Each issue has been corrected or addressed**

Comments as needed:

Clinic Treatment Coordinator Signature

Date

*Note: For questions 4 and 5, Psychiatric services are reviewed with each progress note. Due to changes in procedures, there may not be Annual and 6-month Reviews for psychiatry in the charts prior to 2014. Use N/A to indicate not available.

Notice of Privacy Practices--Acknowledgment of Receipt

By signing this acknowledgment form I am confirming that:

I received a copy of OPWDD's Notice of Privacy Practices and the Summary;

I understand that I can contact my local DDSOO to get more information about my privacy rights in OPWDD.

Individual's name (please print): _____

Individual's signature: _____ Date: _____

If applicable (when the individual is not able to understand the notice):

Name of contact person: _____

Relationship to the Individual: _____

Signature of contact: _____ Date: _____

PRE-SEDATION MEDICATIONS CHECKLIST

Name _____ Date _____

Complete the following checklist for pre-sedation medication:

- **Vital Signs prior to the administration of the pre-sedation medication**

1. Time _____ Blood Pressure _____

2. Temperature _____ Pulse _____ Respiration _____

- **Use of any wheelchair Y/N _____ Y strap or T strap _____**

- **Vital Signs upon return to residence**

1. Time _____ Blood Pressure _____

2. Pulse _____ Respiration _____

- **Vital Signs two hours after return to residence**

1. Time _____ Blood Pressure _____

2. Pulse _____ Respiration _____

- **Vital Signs four hours after return to residence**

1. Time _____ Blood Pressure _____

2. Pulse _____ Respiration _____

Contact the RN prior to the administration of the pre-sedation medications or following the procedure if:

- The blood pressure is under _____ or over _____
- The pulse is under _____ or over _____
- The respirations are under _____ or over _____
- The temperature is under _____ or over _____
- There is vomiting
- There is a decrease in regular function of the arms and/or legs
- There is a change in routine walking/standing ability
- There is lethargy, weakness, or a change in usual orientation to person, place, time or a change in Response to verbal direction for more than _____ minutes/hours
- There is unusual restlessness, apprehension, and/or an increase in self injurious behavior (SIB)
- There is a decrease in urination/unusual incontinence of urine and/or stool
- There is a decrease in fluid and/or food intake
- There is increased cough and/or congestion
- Rash

POST HOSPITALIZATION CHECKLIST

(Notify RN that a consumer has returned from the hospital and review discharge orders)

Complete the following steps every ___ hours for ___ Days at the direction of the Supervising RN.

Name _____

◆Enter Date ⇨						
◆Enter time ⇨						
◆Enter your initials ⇨						
◆Check temperature and record ⇨ →Call RN if temperature is above or below consumers normal range (_____ to _____) →If fever med is given (per RN), repeat temp after 1 hour & call RN if temperature is still elevated						
◆Check pulse and record ⇨ →Call RN if pulse is < 60 or > 120 →Call 911 if chest pain occurs						
◆Check respirations and record ⇨ →Call RN if respirations are < 14 or > 24 or for a persistent cough →Call 911 if there is difficulty breathing (is breathing hard, in a strange way or needs to sit up or lean forward to breathe)						
◆Check blood pressure and record ⇨ →Call RN if systolic pressure (top #) is < 90 or > 160						
◆Last Bowel Movement at hospital_____ . Record BM here⇨ (Enter "none" if no BM during the charting period) →Call RN per BM Protocol or no BM for 48 hours. Or more than _____ BM in 24 hours →Call RN if Abdominal pain, cramps or discomfort. Call 911 for severe abdominal pain						
◆Monitor skin integrity & record ⇨ (Enter "okay" if no skin problems are present) →Call RN for a new rash, reddened or broken skin						
◆Check Surgical wound if present ⇨ (Enter "No drainage" if none or describe any drainage)t →Call RN if there is an increase in drainage or more than a ¼ inch of redness around the wound Call RN if the consumer removed the dressing(s)						
◆Monitor color and record ⇨ (Enter "Normal" - skin color is normal for this person, or "Flushed" - redness of face or skin, or "Pale" - loss of color in face or skin, or "Cyanotic" - bluish/greyish color to lips, face or skin) →Call RN if flushed, pale, or cyanotic						
◆Monitor pain status and record ⇨ (Enter yes if the consumer required pain medication) →Call RN if pain is not relieved by medication in 1 hour						
◆Monitor appetite ⇨ (Enter "Eating and Drinking fluids", or "Not eating/drinking") →Call RN if consumer refuses a meal or fluids						
◆Monitor urine and record urine output ⇨ Enter 'urinated' or 'no urination' →Call RN if consumer does not void (urinate) during an 8 hour shift.						

Name: _____ DOB: _____

Allergies: _____

Guidelines

- * The administration of the OTC medication may not exceed 48 consecutive hours unless otherwise prescribed by the MD.
- * Staff are to notify the RN/MD should they have any concerns about the individual's condition
- * Staff are to notify the nurse on the next business day of any OTC meds administered
- * Medications that ARE NOT prescribed should be eliminate by the MD by drawing a line through that medication and placing the date & their initials next to the medication being eliminated.
- * For additional OTCs, the MD is to list them in the # 11 space below, indicating the condition for which the OTC is to be used; including the dose, frequency and any specific related instructions

*Over the Counter (OTC) medications may be given to _____ following directions as indicated below:

- | | |
|--|---|
| <ol style="list-style-type: none"> 1. Fever: Tylenol (acetaminophen) may be given for a temperature reading of 101 F or above. The dose is 325 mg, administer 2 tabs every 4 hours or give one 650 mg suppository every 4 hours. Liquid Tylenol may be used in the same dosage. Recheck temp every 4 hours and if still elevated, contact the RN/MD. 2. Headache: Tylenol (acetaminophen) may be given. The dose is 325 mg, administer 2 tabs every 4 hours or give one 650 mg suppository every 4 hours. Liquid Tylenol may be used in the same dosage. If the headache is not relieved or appears severe, call RN/MD. 3. Indigestion: Give Mylanta 2 tablespoons (30 cc) or Mylanta 1 tablet every 4 hours. If indigestion worsens or there is no improvement within 30 minutes, contact RN/MD. 4. Vomiting: Do not feed for 1 hour after last vomiting episode and then provide a clear liquid diet for 12 hours. Avoid milk, citrus foods and juices, spicy & fatty foods. Encourage slowly sipping fluids. Take vital signs every shift for 2 consecutive shifts. Report any further vomiting, abnormal vital signs, or any behavioral changes/somatic complaints to the RN/MD 5. Diarrhea: Administer Kaopectate 30 cc. (2 Tablespoons) <u>after the (3rd)</u> third loose stool and after each loose stool thereafter up to 6 times in 24 hours. If loose stools continue after the 3rd dose, contact the RN/MD. Hold any laxatives or stool softeners while the diarrhea continues. Encourage fluids. 6. Nasal Congestion: Provide Saline Nasal Spray 2-3 sprays into each nostril up to 3x/day. | <ol style="list-style-type: none"> 7. Sore Throat: Tylenol (acetaminophen) may be given. The dose is 325 mg, administer 2 tabs every 4 hours or give one 650 mg suppository every 4 hours. Liquid Tylenol may be used in the same dosage. May also use Chloraseptic spray-1 spray every 2 hours. If no relief after 4 hours, contact the RN/MD. 8. Scrapes/Scratches: After washing with warm soap & water, pat dry and apply Bacitracin or Polysporin or Triple Antibiotic ointment topically up to 3x/day. Do not use ointments containing Neomycin. If signs of infection occur, notify RN/MD. 9. Itchy Rash: Administer Benadryl plain (Diphenhydramine) 25 mg. every 8 hours or Calamine Lotion (not Caladryl) as needed or 1% Hydrocortisone cream in small amounts up to 3x/day, wear gloves & rub in well. Do not give if consumer is on Mellaril or Serentil. If no relief or rash appears to worsen, contact RN/MD. 10. Musculoskeletal Aches/Pains: Assuming NO Aspirin allergies; Give Motrin (Ibuprofen) 400 mg, every 6 hours. If no relief after 24 hours or if condition appears to worsen, notify RN/MD. 11. Other OTCs: _____
_____ 12. Annual Influenza Vaccine: _____ |
|--|---|

Doctor's Signature: _____
 Date: _____
 Nurse's Signature: _____
 Date: _____

ADULT OVER THE COUNTER MEDICATION APPROVAL FORM

Name: _____

Allergies: _____

INSTRUCTIONS FOR HEALTH CARE PROVIDERS: Please **approve** the over-the-counter medications below which may be given for the stated purpose. **Administration of an OTC medication will NOT exceed two consecutive days, unless so specified.**

INSTRUCTIONS FOR AMAPs: Chart and document OTC medication administration on the MAR. Notify the supervising RN through the team process. Contact RN/RN-On-Call for approval to administer a second dose within the same day unless approval is provided for more than 1 dose. Do not exceed two consecutive days.

The use of the approved over-the-counter medications below is permitted when administered in accordance with the following to ensure that the medication is appropriate and that there will be no contraindications:

✓ if approved	Medication & Strength	Dosage/Route/Frequency/ Duration	Indications For Use	MDD
	Acetaminophen 325 mg tabs	2 tabs po q4h prn	<input type="checkbox"/> For temp > 101 <input type="checkbox"/> For headache <input type="checkbox"/> For minor muscle aches <input type="checkbox"/> For menstrual discomfort <input type="checkbox"/> Other _____	8 tabs
	Mylanta/Maalox liquid antacid	1 tbsp po q4h prn	For minor stomach upset and heart burn	6 doses (6 tbsp)
	Guaifenesin cough syrup	2 tsps po q4h prn	For minor cough without temperature over 100 degrees	4 doses (8 tsp)
	Triple Antibiotic Ointment (Neosporin)	Apply small amount to affected area three times a day prn	To prevent infection in minor cuts, scrapes and burns.	Three times a day

I have reviewed and indicated which of the above appropriate medications can be used for this individual along with the prescribed medications already in use. There are no contraindications.

Date: _____

Practitioner: _____

All over-the-counter orders expire 12 months from the date signed.

ORDERING MEDICATIONS PROTOCOL (DRAFT 2010)

Per 633.17 Regulation: "all medications will be ordered, prescribed or approved by a health care practitioner, administered by approved medication staff, nurses, Family Care Providers/Substitute Providers, and/or family and stored according to regulation standards."

The supervising RN will assign and train staff to re-order medications on a timely basis. The RN/RN-on-Call will be immediately notified to provide direction and appropriate recourse if medication is not available: ie- pharmacy closed, medication not picked up/delivered, assigned staff did not order medications.

Important components of ordering medications:

- Assigned person name(s)
- Day(s)/shift to re-order or for Day Program to call residence
- Sample of any document used to fax/call in refills to pharmacy
- Amount of medication left when medication is to be ordered:
 - Consider pills, ointments, drops, liquids, suppositories, OTCs
- Where extra medication is stored at residence
- How to assist specific individuals who are independent in Self-administration or Self-management of medications to have ongoing medication supply
- When and how to send medications to day program
 - When medications are transferred-day/time
 - Transfer of medication on Medication Specific sheet
 - Transfer of medication form
 - How medications are transported-medication box, on bus, by staff
- All AMAPs and LPNs must be aware that if the last of the medication is used, there must be more available for the next medication administration:
- Team designation of where to look for ordered medication- log book, med room, etc
- Who to call if staff is working alone and unable to pick up/no delivery possible
- Where to find unfilled or existing prescriptions for medications without refills
- Process for obtaining new prescriptions
- Notification of supervising RN/RN-On-Call

Please post "Ordering Medications" protocol in med room/area to ensure that all medication approved staff, including float staff, are able to access this information.

NYS OPWDD Nutrition Assessment

Name:	DOB:	Age:	Date:
Residence:	Gender: select		TAB ID#:
Program:	Physician:		

Folate (ng/ml)					
Vitamin B-12 (pg/ml)					
Ferritin (ng/ml)					
Total Iron (mcg/dl)					
TIBC (%)					
Fe Saturation (%)					
Total Cholesterol (mg/dl)					
HDL-Chol (mg/dl)					
LDL-Chol (mg/dl)					
Triglycerides (mg/dl)					
Total Chol:HDL					
TSH (uIU/ml)					
Free T4 (ng/dl)					
Hgb A1c					
25-OH Vitamin D					
GFR					
Nutritionally significant diagnostic tests / procedures:					

Nutrition-Focused Physical Findings

Oral Condition (check all that apply): <input type="checkbox"/> No noted concerns <input type="checkbox"/> Edentulous <input type="checkbox"/> Dry mouth <input type="checkbox"/> Loose teeth <input type="checkbox"/> Some missing teeth <input type="checkbox"/> Drooling <input type="checkbox"/> Other
Oral Function Select from list
Comments:
Skin Condition: <input type="checkbox"/> Intact <input type="checkbox"/> Impaired Comments:
Intake Solids: select from list Comments:
Intake Fluids: select from list Comments:
Bowel Regularity: <input type="checkbox"/> Maintain with Diet <input type="checkbox"/> Maintained with Diet and Medication
Comments:
Vision: select from list Hearing: select from list

Client History

Medical Diagnosis:
Other Client History:

Comparative Standards

Estimated Daily Nutritional Needs	Reference Standards
Calories	
g Protein	
mL Fluid	
Comments:	

NYS OPWDD Nutrition Assessment

Name:	DOB:	Age:	Date:
Residence:		Gender: select	TAB ID#:
Program:		Physician:	

Summary

Nutrition Diagnosis (PES Statement)

Problem #1: select from list

Other:

Related to:

As Evidenced by:

Problem #2: select from list

Other:

Related to:

As Evidenced by:

Problem #3: select from list

Other:

Related to:

As Evidenced by:

Nutrition Intervention

Nutrition Prescription:

Intervention #1:

Intervention #2:

Intervention #3:

Intervention #4:

Intervention #5:

Intervention #6:

Individual Goals:

Nutrition Monitoring and Evaluation Plan

#1:

#2:

#3:

#4:

#5:

#6:

Completed by:

Name, Credentials

Date:

Neurological Reporting Checklist

(For monitoring persons with a change in consciousness or function)

Complete this form after an observed neurological change (such as a seizure or change in consciousness).

Name _____

◆Enter Date ⇨					
◆Enter time ⇨					
◆Enter your initials ⇨					
PRE-ICTAL PHASE: (AURA)					
◆Check changes in behavior, (observed before the neurological event occurred), and record ⇨ <small>* Describe any changes noted before the event such as a change in behavior, mood or expression. * Describe any changes reported to you by the consumer before the event was observed. Changes could include an alteration of vision, hearing, smell or taste. Also a headache or tingling sensation. * Enter "no change" if no changes were noted before the event was observed</small>					
ICTAL PHASE:					
◆Check level of consciousness and record ⇨ <small>* Enter "Unconscious" if the consumer did not respond to you in any way and could not remain upright (if the consumer fell to the floor or slumped over in the chair) * Enter "Unresponsive" if the consumer appeared awake but did not respond to verbal prompts (such as 'are you okay?') * Enter "Altered" if the consumer appeared confused or was unable to talk normally (such as mumbling and/or repeating word) * Enter "no change" if no changes were noted. (The consumer was awake and alert and could talk normally during the event)</small>					
◆Observe for physical movements and/or changes and record ⇨ <small>* Enter "tremors" and describe their location if the consumer demonstrated twitching or shaking of body parts (such as lips, eyes, facial muscles and/or arms and legs) * Enter "rigid" and describe the location if the consumer demonstrated the stiffening of muscles (such as the arms and legs) * Enter "limp" if the consumer dropped to the floor or slumped over in the chair and had no muscle tone (muscle were soft and weak) * Enter "blank stare" if the consumer stared into space with no response to verbal prompts. * Enter "impaired breathing" if the consumer had a change in breathing patterns (appeared to have difficulty breathing or was breathing faster/ deeper than usual) * Describe unusual behavior (such as repetitive and/or purposeless behavior that the consumer does not normally demonstrate) → Call 911 immediately if the consumer is severely injured, (such as head injury, severe bleeding or broken bone) or if the consumer stops breathing</small>					
◆Time the duration of the event and record ⇨ <small>* Record only the length of physical symptoms (such as staring, rigid muscles, limp muscles, twitching, shaking and/or repetitive behaviors) → Call 911 immediately if the consumer is not known to have epilepsy, seizures, or if the event lasts longer than _____ minutes..</small>					
POST-ICTAL PHASE:					
◆Time duration of unresponsiveness after the event and record ⇨ <small>*Record the time, if any, between the end of physical symptoms and when the consumer is responsive</small>					
◆Observe mental status after the event and record ⇨ <small>*Enter the consumer's mental status after the event (such as drowsy, weak, tired, or sleeping)</small>					
◆Take vital signs, if indicated, and record ⇨ <small>→ Call RN if vital signs are outside of normal range.</small> BP normal range _____ to _____ Pulse normal range _____ to _____ Resp. normal range _____ to _____					

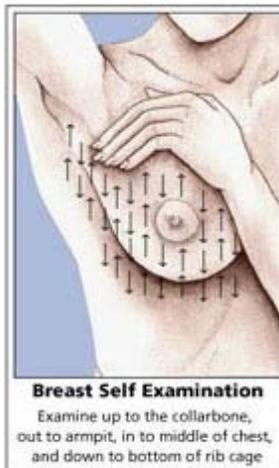
Document All telephone calls to RN/Physician on PRN/HCP notes.

Monthly Breast Exam

Year: _____

<u>Month</u>	<u>Signature of Staff Completing Exam</u>	Check one	
		<u>negative</u>	<u>positive</u>
January	_____	_____	_____
February	_____	_____	_____
March	_____	_____	_____
April	_____	_____	_____
May	_____	_____	_____
June	_____	_____	_____
July	_____	_____	_____
August	_____	_____	_____
September	_____	_____	_____
October	_____	_____	_____
November	_____	_____	_____
December	_____	_____	_____

Move around the breast in an up and down pattern starting at an imaginary line drawn straight down their side from the underarm and moving across the breast to the middle of the chest bone (sternum or breastbone). Be sure to check the entire breast area going down until you feel only ribs and up to the neck or collar bone (clavicle). **Any positive findings should be documented in the health care progress notes and reported to the PCP immediately for further clinical evaluation.**



MOLST LEGAL REQUIREMENTS CHECKLIST FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES

LAST NAME/FIRST NAME

DATE OF BIRTH

ADDRESS

Note: Actual orders should be placed on the MOLST form with this completed checklist attached. Use of this checklist is required for individuals with developmental disabilities (DD) who lack the capacity to make their own health care decisions and do not have a health care proxy. Medical decisions which involve the withholding or withdrawing of life sustaining treatment (LST) for individuals with DD who lack capacity and do not have a health care proxy must comply with the process set forth in the Health Care Decisions Act for persons with MR (HCDA) [SCPA § 1750-b (4)]. Effective June 1, 2010, this includes the issuance of DNR orders.

Step 1 – Identification of Appropriate 1750-b Surrogate from Prioritized List. Check appropriate category and add name of surrogate.

- _____ a. 17-A guardian _____
- _____ b. actively involved spouse _____
- _____ c. actively involved parent _____
- _____ d. actively involved adult child _____
- _____ e. actively involved adult sibling _____
- _____ f. actively involved family member _____
- _____ g. Willowbrook CAB (full representation)
- _____ h. Surrogate Decision Making Committee (MHL Article 80)

Step 2 – 1750-b surrogate has a conversation or a series of conversations with the treating physician regarding possible treatment options and goals for care. Following these discussions, the 1750-b surrogate makes a decision to withhold or withdraw LST, either orally or in writing.

Specify the LST that is requested to be withdrawn or withheld: _____

_____ Decision made orally

Witness – Attending Physician

Second Witness

_____ Decision made in writing (must be dated, signed by surrogate, signed by 1 witness and given to attending physician).

LAST NAME/FIRST NAME

DATE OF BIRTH

Step 3 – Confirm individual’s lack of capacity to make health care decisions. Either the attending physician or the concurring physician or licensed psychologist must: (a) be employed by a DDSO; or (b) have been employed for at least 2 years in a facility or program operated, licensed or authorized by OPWDD; or (c) have been approved by the commissioner of OPWDD as either possessing specialized training or have 3 years experience in providing services to individuals with DD.

Attending Physician

Concurring Physician or Licensed Psychologist

Step 4– Determination of Necessary Medical Criteria.

We have determined to a reasonable degree of medical certainty that **both** of the following conditions are met:

(1) the individual has one of the following medical conditions:

- _____ a. a terminal condition; (briefly describe _____
_____); or
- _____ b. permanent unconsciousness; or
- _____ c. a medical condition other than DD which requires LST, is irreversible and which will continue indefinitely (briefly describe _____
_____)

AND

(2) the LST would impose an extraordinary burden on the individual in light of:

- _____ a. the person’s medical condition other than DD (briefly explain _____
_____) and
- _____ b. the expected outcome of the LST, notwithstanding the person’s DD (briefly explain _____
_____)

If the 1750-b surrogate has requested that artificially provided nutrition or hydration be withdrawn or withheld, one of the following additional factors must also be met:

- _____ a. there is no reasonable hope of maintaining life (explain _____
_____); or
- _____ b. the artificially provided nutrition or hydration poses an extraordinary burden (explain _____

_____).

Attending Physician
Revised 3/18/2013

Concurring Physician
Page 2 of 3

LAST NAME/FIRST NAME

DATE OF BIRTH

Step 5 – Notifications. At least 48 hours prior to the implementation of a decision to withdraw LST, or at the earliest possible time prior to a decision to withhold LST, the attending physician must notify the following parties:

_____ the person with DD, unless therapeutic exception applies
notified on ___/___/___

_____ if the person is in or was transferred from an OPWDD residential facility

_____ Facility Director notified on ___/___/___

_____ MHLS notified on ___/___/___

_____ if the person is not in and was not transferred from an OPWDD residential facility

_____ the director of the local DDSO notified on ___/___/___

Step 6 - I certify that the 1750-b process has been complied with, the appropriate parties have been notified and no objection to the surrogate’s decision remains unresolved.

Attending Physician

Date

Note: The MOLST form may ONLY be completed with the 1750-b surrogate after all 6 steps on this checklist have been completed.

This form should remain on-site until completed and reviewed by the supervising RN 6/10

CNYDSO MEDICATION REGIMEN REVIEW

To be completed no less than a semi-annual basis by an RN, NP, Physician, PA or Pharmacist

Name: _____ DOB: _____

Review Period From _____ to _____

I have:

- Reviewed all the medication that this person has taken during the review period including routine, PRN, over-the-counter, topical, time-limited, and discontinued medications.
- Reviewed the person's medication record for potential adverse reactions, allergies, interactions, contraindications, or irregularities (e.g. medications not taken in accordance with the usual recommendations).
- Reviewed any related lab work.
- Reviewed the rationale, reason, or purpose for the medication(s).
- Assessed this person's response to medication therapy to determine if the medication is achieving the desired effect(s).
- Reviewed the concomitant administration of this person's medications.
- Reviewed the PRN medication usage, including the frequency of use and effectiveness of the medication. (Any recommendations regarding PRN medication including the appropriateness of continuation of orders for medication not required during the review period, and the criteria for use shall be made to the prescriber based upon said review).

Findings:

<input type="checkbox"/>	No Significant findings (Medication regime is achieving desired effects without potential adverse reactions, interactions, contraindications, irregularities)
<input type="checkbox"/>	Recommendations: <ul style="list-style-type: none"><input type="checkbox"/> Labwork<input type="checkbox"/> Medication Administration Change (change in time, form, instructions)<input type="checkbox"/> Potential Adverse interaction or contraindication<input type="checkbox"/> Potential for allergy or sensitivity<input type="checkbox"/> Monitoring of EPS/TD signs and symptoms needed<input type="checkbox"/> other

Action:

<input type="checkbox"/>	No action needed
<input type="checkbox"/>	Recommendations sent to prescriber
<input type="checkbox"/>	Recommendations sent to Psychologist/behavioral Specialist for Psychotropic medication

Reviewer and title _____ Date: _____

Practitioner's response:

CNYDSO MEDICATION REGIMEN REVIEW

To be completed no less than a semi-annual basis by an RN, NP, Physician, PA or Pharmacist

Name: _____ DOB: _____

I have:

- Reviewed all the medication that this person has taken during the review period including routine, PRN, over-the-counter, topical, time-limited, and discontinued medications.
- Reviewed the person's medication record for potential adverse reactions, allergies, interactions, contraindications, or irregularities (e.g. medications not taken in accordance with the usual recommendations).
- Reviewed any related lab work.
- Reviewed the rationale, reason, or purpose for the medication(s).
- Assessed this person's response to medication therapy to determine if the medication is achieving the desired effect(s).
- Reviewed the concomitant administration of this person's medications.
- Reviewed the PRN medication usage, including the frequency of use and effectiveness of the medication. (Any recommendations regarding PRN medication including the appropriateness of continuation of orders for medication not required during the review period, and the criteria for use shall be made to the prescriber based upon said review).

Findings:

<input type="checkbox"/>	No Significant findings (Medication regime is achieving desired effects without potential adverse reactions, interactions, contraindications, irregularities)
<input type="checkbox"/>	Recommendations: <ul style="list-style-type: none"><input type="checkbox"/> Labwork<input type="checkbox"/> Medication Administration Change (change in time, form, instructions)<input type="checkbox"/> Potential Adverse interaction or contraindication<input type="checkbox"/> Potential for allergy or sensitivity<input type="checkbox"/> Monitoring of EPS/TD signs and symptoms needed<input type="checkbox"/> other

Action:

<input type="checkbox"/>	No action needed
<input type="checkbox"/>	Recommendations sent to prescriber
<input type="checkbox"/>	Recommendations sent to Psychologist/behavioral Specialist for Psychotropic medication

Reviewer and title _____ Date: _____

Practitioner's response:

10/2010 revised

CNY DDSOO MEDICATION EVENT REPORTING FORM-8/13/12

Name of Consumer:		Date Of Birth:	Date of Medication Event: Time of Medication Event:
Location of Event:	Team:	<input type="checkbox"/> Observed/Witnessed OR: <input type="checkbox"/> Discovered Time Discovered:	
Staff Person/title reporting the medication event:		Staff person(s)/Title(s) responsible for medication event:	

Medications involved:

Description of Medication Event:

- Continue descriptive information on the back

Contributing circumstances (List any factors that may have contributed to this event)

1. <input type="checkbox"/> Behavior Problems	2. <input type="checkbox"/> Conflicting Assignments	3. <input type="checkbox"/> Different shift/ET/OT or AMAP Float
4. <input type="checkbox"/> Distraction	5. <input type="checkbox"/> Consumer away from site	6. <input type="checkbox"/> Order confusing
7. <input type="checkbox"/> Medical Emergencies	8. <input type="checkbox"/> New Assignment	9. <input type="checkbox"/> Not enough time
10. Other:		

RN Notification (ASAP):	Date:	Time:
HCP/Doctor notification (if directed):	Date:	Time:
Supervisor notification (if directed):	Date:	Time:
Family/Guardian notification (If directed):	Date:	Time:

SECTION II INTERVENTION – TO BE COMPLETED BY SUPERVISING NURSE

What care, was provided to the individual and what, if any, corrective action was done with staff:

- *Continue corrective action comments on the back

Was an incident Report filed? <input type="checkbox"/> Yes <input type="checkbox"/> No	<i>*A reportable incident occurs when a person served is evidencing a marked adverse effect or his/her health or welfare is in jeopardy because of the medication event.</i>
	<i>*A Serious reportable incident occurs when the persons health or welfare is so compromised as to result in hospital admission</i>

Signature of RN _____ TTL _____

ANNUAL/SEMI ANNUAL REVIEW OF MEDICAL FOLLOW-UP

Name: _____

APPOINTMENT	DR. NAME ADDRESS PHONE NUMBER	LAST VISIT	NEXT VISIT DUE	SCHEDULED APPOINTMENT
Annual PE				
OTC Orders				
TB Testing				
Primary Care Follow-up				
Tetanus Booster				
Flu Vaccine				
Dental				
Audiology				
Gynecology				
Neurology				
Podiatry				
Psychiatry				
Vision				
Other				
Other				

OPWDD – Central NY DDSO – Syracuse

ARTICLE 16 CLINIC APPLICATION

Applicant's Name: _____ DOB: _____

TABS #: _____ Social Security #: _____

Address: _____ Phone: () _____

Medicare #: _____ Medicaid #: _____

Person completing application/Relationship to applicant: _____

Service Coordinator: _____ Agency: _____

Address: _____

Phone: () _____ Email: _____

Type of Residence (Please check):

- | | | |
|---|--|---|
| <input type="checkbox"/> Alone | <input type="checkbox"/> Parents or member of family | <input type="checkbox"/> OPWDD/Agency Residence |
| <input type="checkbox"/> Homeless/Shelter | <input type="checkbox"/> Family Care Provider | <input type="checkbox"/> Friends/Housemates |
| <input type="checkbox"/> DSS/Foster Care | <input type="checkbox"/> Other (please specify) | |

Name of Residential Contact/Address/Phone:

Does applicant have a legal guardian? Yes (see *** below) No

Name of legal guardian: _____ Phone: () _____

Address: _____ Email: _____

May we contact you with Agency updates and information? Yes No

***** If the person has a legal guardian, the guardian must be notified of the referral being made and copies of Guardianship Affidavit must be submitted with referral.**

Medical Information

Primary Care Physician: _____ Phone: () _____

Address: _____

Psychiatrist: _____ Phone: () _____

Allergies: _____

List of medications: _____

Qualifying Diagnosis: _____ Documentation Present: Yes No

Seizure History (include type, frequency, date of last known seizures): _____

TB Status _____ Record of two negative Mantoux: Dates _____

Physical Limitations: _____

Current ISP Date: _____

Is the consumer currently receiving any other Article 16 Clinic services? Yes No

If so, ongoing appointments must **NOT** occur on the same day at two different Article 16 Clinics.

Also, please provide the service, name of agency, address, phone number & contact to avoid duplication of service. _____

Services Requested:

- | | | | |
|-------------------------------------|--|------------------------------------|---|
| <input type="checkbox"/> Psychiatry | <input type="checkbox"/> Occupational Therapy | <input type="checkbox"/> Nutrition | <input type="checkbox"/> Audiology |
| <input type="checkbox"/> Psychology | <input type="checkbox"/> Speech Language Pathology | <input type="checkbox"/> Nursing | <input type="checkbox"/> Physical Therapy |

Briefly describe the individual's need for service:

Signature of person completing form: _____ Date: _____

Address: _____

CLINICAL COMPETENCY: INSULIN ADMINISTRATION

The RN/LPN noted below has completed training in Diabetes and Insulin Administration and must now demonstrate clinical competency.

INSTRUCTIONS

All items must be checked YES, NO or N/A for attainment of the competency.

All attempts at attainment are to be documented.

	YES	N/A	NO
1. Recognizes signs and symptoms of insulin shock.			
2. Recognizes signs and symptoms of diabetic coma.			
3. Follows facility process to determine current drug order.			
4. Checks practitioner's order for glucometer testing and reading and reviews need for coverage, if indicated.			
5. Observes the 5 rights of medication administration.			
6. Gathers necessary equipment including alcohol, insulin, syringe, and sharps container.			
7. Checks concentration & type, expiration date, and appearance of insulin.			
8. Washes hands			
9. Reads label three times before administration.			
10. Demonstrates knowledge of site rotation, selecting appropriate site for administration.			
11. Cleans rubber stopper on the insulin bottle with alcohol swab. Let completely dry. Do not blow on to speed dry			
12. Remove cap from needle, draws air into the syringe by retracting plunger to prescribed insulin dosage line.			
13. Hold insulin bottle steady on tabletop, and push needle straight down into rubber cap on the bottle. Push down on the plunger to inject air into the insulin bottle.			

14. Leave the needle in the bottle and the plunger pushed all the way in while you pick up the bottle and turn it upside down, the point of the needle should be covered by the insulin. Pull the correct amount of insulin into the syringe by pulling back on the plunger.
15. Check for air bubbles on the inside of the syringe. If you see air bubbles, keep the bottle upside down and push the plunger until the air goes back into the bottle.
16. Removes syringe from bottle and recheck. If you need to set the syringe down before injecting, recap syringe and place on clean, flat surface until ready to inject.
17. Explains procedure to consumer and provides privacy.
18. Uses process that identifies the drug up to the point of administration.
19. Wash hands and Don gloves
20. Choose injection site with fatty tissue, such as back of arm, top and outside of thigh, abdomen (except one inch circle around umbilicus), or buttocks. It is not required to wipe with alcohol.
21. Gently pinch a fold of skin between thumb and forefinger and inject strait in.
22. Push needle through the skin as quickly as you can and push the plunger in to inject the insulin.
23. Pull the needle straight out. Activate safety device on syringe. Cover injection site with cotton ball or gauze for 5-8 seconds. Do Not Rub.
24. Discards syringe/needle in sharps box. Do not recap needle.
25. Removes gloves and washes hands.
26. Accurately records administration.

NAME

SS # (last 4 digits)

TITLE

RN EVALUATOR

SITE

DATE

HOT PACK CHECKLIST

3/1/07

Check HCP order for directions prior to Applying Hot Pack (**Call RN if unsure of directions**) **DO NOT MICROWAVE**

Name _____

◆Enter Date ⇨						
◆Enter your initials ⇨						
◆Enter time that hot pack was applied ⇨						
◆Enter time that hot pack was removed ⇨						
◆Check hot pack prior to use and initial that no holes or leakage were found OR ⇨ →Call RN and do not use hot pack if any leaks or holes are found						
◆Check hot pack after use and initial that no holes or leakage were found. OR ⇨ →Call RN if any leaks or holes are found. DO NOT REPAIR OR REUSE DAMAGED HOT PACK						
◆Check the indicated skin area prior to hot pack and initial that skin color is normal and no drainage is visible OR ⇨ →Call RN if skin area is red, blistered, swollen, draining or painful						
◆Check the indicated skin area after using the hot pack and initial that skin color is normal and no drainage is visible OR ⇨ →Call RN if skin area remains reddened after _____ minutes →Call RN skin is blisters, swollen, draining or painful						
◆Check consumer after hot pack and initial if no changes in condition OR ⇨ →Call RN if consumer complains of pain or burning →Call RN if consumer shows signs of pain or discomfort →Call RN if there is a change in consciousness →Call RN if consumer complains of light headedness →Call RN if consumer has any difficulty breathing →Call RN if Vomiting occurs more than once per day →Call RN if refuses scheduled meals →Call RN if refuses typical drinks						
◆Initial if no changes or concerns are present at this time OR ⇨ →Check vital signs if you need to report any changes or concerns to the RN: 1 Check Temperature and record if needed 2 Check Pulse and record if needed 3 Check Respirations and record if needed 4 Check Blood Pressure and record if needed	T:					
	P:					
	R:					
	BP:					

HOSPITAL DISCHARGE

Review with RN/house director before leaving for hospital discharge. When you arrive at the hospital to pick up an individual, be sure to ask the following questions and refer any concerns immediately to the supervising RN prior to the actual discharge.

Name: _____ Staff: _____ Date: _____

√	PAPERWORK	COMMENTS
	Ask for copies of all labwork, progress notes, consultation reports, x-rays and scan reports and other paperwork as directed by RN	
	Any restrictions?	
	Return to day program when?	
	When the next MD appointment should be?	
	MOLST form– retrieve the MOLST form from the hospital record No MOLST form, is there a non-hospital DNR order written for discharge?	
	Sitter service or staff documentation?	

√	HOW DOES THE PERSON LOOK?	COMMENTS
	Difficulty breathing, O2 sat under 90 on room air, pale or flushed skin.	<input type="checkbox"/> No <input type="checkbox"/> Yes If yes, contact RN
	No fever for the last 24 hours?	<input type="checkbox"/> No <input type="checkbox"/> Yes If yes, contact RN
	Last BM, if over 2 days ago, call RN.	<input type="checkbox"/> No <input type="checkbox"/> Yes If yes, contact RN
	Vomited in last 24 hours?	<input type="checkbox"/> No <input type="checkbox"/> Yes If yes, contact RN
	Ate or had G-tube feeding today?	<input type="checkbox"/> No <input type="checkbox"/> Yes If no, contact RN
	When was last meal? Diet change? <input type="checkbox"/> No <input type="checkbox"/> Yes	
	Any skin irritation, redness, or breakdown? Location _____	<input type="checkbox"/> No <input type="checkbox"/> Yes If yes, contact RN
	Ask and check if a nurse took out all IVs (hep locks, PICC lines-unless otherwise specified)?	
	Any dressings on wounds or IV site?	<input type="checkbox"/> No <input type="checkbox"/> Yes If yes, contact RN

√	MEDICATIONS	COMMENTS
	Is there a resume all previous medications order?	
	Are there any medications changes?	
	What were the last medications administered today and at what time?	
	Are there new medications and/or new prescriptions? Right person <input type="checkbox"/> Right medication <input type="checkbox"/> Right dosage <input type="checkbox"/> Right time <input type="checkbox"/> Right route <input type="checkbox"/> >>G or J tube? <input type="checkbox"/>	<input type="checkbox"/> No <input type="checkbox"/> Yes Do you have the new prescriptions?

√	EQUIPMENT/MEDS	COMMENTS
	Any medications, adaptive equipment (wheelchair, splints, dining utensils, pastime activities)?	

HEALTH CARE APPOINTMENTS

DATE	NOTES

Consumer: _____

Date	Notes

Head Injury Checklist

Complete this form every 4 hours for the first 24 hours or as directed by RN.

Name _____

◆Enter Date ⇨						
◆Enter time ⇨						
◆Enter your initials ⇨						
◆Check pulse and record ⇨ <i>→ Call RN if pulse is < 60 or > 120</i>						
◆Check respirations and record ⇨ <i>→ Call RN if respirations are < 14 or > 24</i> <i>→ Call 911 if there is difficulty breathing (is breathing hard, in a strange way or needs to sit up or lean forward to breathe)</i>						
◆Check blood pressure and record ⇨ <i>→ Call RN if pressure (top #) is < 90 or > 160</i>						
◆Check mental Status and record ⇨ Enter "No changes" - for this person, or "Irritable" - (excessive reponse or excitability), "lethargic" - (very drowsy & groggy but can wake up) "disorientated" = (unusually confused) AND <i>→ Call 911 if unresponsive or unusually confused</i> <i>→ Call 911 if unable to wake up when sleeping</i> <i>→ Call RN if unusually sleepy or lethargic</i> <i>→ Call RN if a change in communication skills</i> <i>→ Call 911 if an unexpected seizure occurs</i>						
◆Monitor Movement when awake and record ⇨ Enter "No changes" - for this person, OR <i>→ Call RN if falling, or unsteady when walking</i> <i>→ Call RN if unable to grasp objects normally</i> <i>→ Call RN if performs tasks more slowly than usual</i>						
◆Check head-to-toe for changes in condition ⇨ Enter "No Changes" if no changes are noted OR <i>→ Call RN if more swelling or bruising is noted to the injured area or any new bruising or swelling occurs</i> <i>→ Call RN if bleeding from ears, nose or mouth</i> <i>→ Call RN if any stitched area has more bleeding</i> <i>→ Call RN if any drainage or fluid from the nose is observed</i> <i>→ Call RN if any changes in vision are reported or observed</i>						
◆Monitor Pain ⇨ Enter "No Pain" if no pain symptoms are reported or observed OR <i>→ Call RN if unexpected headache or neck pain occurs</i>						
◆Monitor Intake ⇨ Enter "No changes" OR: <i>→ Call RN if Vomiting occurs more than once per day</i> <i>→ Call RN if refuses scheduled meals</i> <i>→ Call RN if refuses typical drinks</i>						

Document All telephone calls to RN/Physician on PRN/HCP notes.

Topic: CLINICAL COMPETENCY: GLUCAGON PREPARATION

The RN/LPN noted below has completed training in the Glucagon injection

INSTRUCTIONS

The supervising RN at the residence or day program will evaluate this task. The instructor must be an RN. The responsibility of the RN will be to determine the appropriate LPN or DA to perform this task. The DA will also be in agreement to take on the responsibilities in this role.

All items must be checked YES, NO or N/A for attainment of the competency.

All attempts at attainment are to be documented.

	YES	N/A	NO
1. Checks prescribers orders and ensures that the order matches the MAR			
2. Washes hands			
3. Remove and flip-off seal from the bottle of glucagon. Wipe rubber stopper on bottle with an alcohol swap.			
4. Remove the needle protector from the syringe, and inject the entire contents of the syringe into the bottle of glucagons. DO NOT REMOVE THE PLASTIC CLIP FROM THE SYRINGE. Remove syringe from the bottle.			
5. Swirl bottle gently until glucagons dissolves completely. GLUCAGON SHOULD NOT BE USED UNLESS THE SOLUTION IS CLEAR AND OF A WATER-LIKE CONSISTENCY.			
6. Using the same syringe, hold bottle upside down and, making sure the needle tip remains in solution, gently withdraw all the solution (1mg mark on syringe) from bottle * (see below)			
7. The plastic clip on the syringe will prevent the rubber stopper from being pulled out of the syringe; however, if the plastic plunger rod separates from the rubber stopper, simply reinsert the rod by turning it clockwise.			
* The usual dose is 1mg (1 unit). Refer to site RN for further direction if prescriber's order is other than 1mg.			

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GLUCAGON INJECTION

The supervising RN at the residence or day program will evaluate this task for one or more consumers at the site, at the discretion of the RN.

All items must be checked YES, NO or N/A for attainment of the competency.
All attempts at attainment are to be documented.

	YES	N/A	NO
<ol style="list-style-type: none"> 1. DON Gloves 2. Cleanse injection site on buttock, arm, or thigh with alcohol swab. 3. Insert the needle into the loose tissue under the cleansed injection site, and inject all of the glucagons solution. If dose is less than 1mg refer to site RN for direction. 4. Apply light pressure at the injection site, and withdraw the needle. Press an alcohol swab against the injection site. 5. Turn the consumer on his or her side to prevent aspiration if consumer vomits. 6. If the consumer doesn't wake up and respond within 15 minutes call 911 or emergency transport to the hospital E.R. as instructed per team process. 7. Remove gloves. 8. Feed the consumer as soon as he/she awakens and is able to swallow. Give him/her fast acting sugar such as; regular soft drink or orange juice, skim milk. 9. Check blood sugar by doing a finger stick. If B.S. is less than 100mg/dl give another 15 gm of instant sugar. 10. Follow up with cracker and cheese or a meat sandwich. 11. Notify the RN/RN on call immediately for further directions. 			

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NAME	SS # (last 4 digits)	TITLE
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RN EVALUATOR	SITE	DATE
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CLINICAL COMPETENCY: GASTROSTOMY TUBE REPLACEMENT

The RN/LPN noted below has completed training in the G-tube curriculum and must now demonstrate clinical competency.

INSTRUCTIONS

The supervising RN at the residence or day program will evaluate this task. The instructor must be a Certified RN in Gastrostomy tube replacement. The responsibility of the certified RN will be to determine the appropriate RN/LPN to perform this task. The LPN will also be in agreement to take on the responsibilities in this role.

All items must be checked YES, NO or N/A for attainment of the competency.

All attempts at attainment are to be documented.

	YES	N/A	NO
<ol style="list-style-type: none"> 1. At the beginning of the shift, checks order for time, rate, amount and type of feeding. 2. Gathers necessary equipment/feeding. 3. Explains all procedures to the consumer and provides privacy. 4. Observes G-site for: Skin integrity (redness, drainage, inflammation, granuloma formation, leakage). 5. Positions consumer in a supine position with head slightly elevated. 6. Cleanses G-tube stoma area with soap and water in circular motion from stoma about 1-1/2" Inches outward. 7. Places a layer of lubricant 1/2" around the stoma site to protect skin from any gastric leaking 8. Places towels around stoma area to aid in absorbing any gastric secretions 			

INSTRUCTIONS

The supervising RN at the residence or day program will evaluate this task for one or more consumers at the site, at the discretion of the RN.

All items must be checked YES, NO or N/A for attainment of the competency.

All attempts at attainment are to be documented.

	YES	N/A	NO
9. Opens replacement tube package			
10. Applies sterile gloves.			
11. Inflates balloon with sterile water with the amt. to be used. Observes symmetry of balloon by gently rolling it between thumb and index finger. Deflate balloon after this check is done. Leave sterile water in syringe.			
12. Lubricates tip of G-tube with generous amount of water soluble solution such as K-Y lubrication. Applies small amount of lubricant at stoma site.			
13. Places plug in the end of the replacement tube and place on the inner service of sterile replacement tube package.			
14. Withdraws solution from the balloon of the old tube (tube that will be replaced). If balloon does not deflate, refer to placement complication guide.			
15. Gently removes old tube. May use gentle pressure to aid in the removal, but never use force. Tube should come free from stoma with gentle pulling. If unable to remove, replaces solution in balloon and refers to the physician/health care provider.			
16. Once non-functional tube is removed, acts quickly to insert new tube, reducing leakage of gastric secretions from stoma site.			

17. Gently guide lubricated tube through stoma and into stomach (aprox. 1-1-1/2 inch on children and 2-4 inches on adults). Be cognizant of adipose tissue and position of balloon in relation to tip of tube.

Replacement tubes should easily advance through the stoma/tract into the stomach. If resistance, bleeding or any difficulty is encountered, stop the procedure and notifies the health care provider.

18. Inflates the balloon while holding tube in place.

19. Withdraws the tube until slight tension is felt from the balloon coming up against the stomach wall.

20. Slides external bumper/disc, secure-lok or baby bottle nipple down toward stoma to maintain tension. Does not apply excessive tension.

21. Leaves stoma open to the air. Cleanses stoma site with mild soap and water QD and prn, pat site completely dry. If site becomes reddened, inflamed, excoriated or has excessive drainage, consults health care provider for treatment.

22. Verifies tube placement and patency:

- aspirates and note amount and type of aspirate. Returns aspirate to stomach unless there is an excessive amount or other concern.
- Instills small amount of air (aprox. 5cc) and listens for air entering stomach with stethoscope.

23. Documentation should include:

Date/time, replaced tube size and type, amount of balloon inflation, stoma assessment, description of aspirate, placement and patency check, reason for replacement, how the consumer tolerated the procedure, any complications, full signature and title of the nurse.

NAME	SS # (last 4 digits)	TITLE
RN EVALUATOR	SITE	DATE

Topic: C1537
Hours: 1.0

**CLINICAL COMPETENCY: GASTROSTOMY FEEDING
PART I**

The RN/LPN noted below has completed training in the G-tube curriculum and must now demonstrate clinical competency.

INSTRUCTIONS

The supervising RN at the residence or day program will evaluate this task for one or more consumers at the site, at the discretion of the RN.

All items must be checked YES, NO or N/A for attainment of the competency.

All attempts at attainment are to be documented.

	YES	N/A	NO
1. At the beginning of the shift, checks order for time, rate, amount and type of feeding. 2. Gathers necessary equipment/feeding. 3. Explains all procedures to the consumer and provides privacy. 4. Observes for: skin condition at the site bowel sounds/patterns abdominal distention abdominal pain/tenderness 5. Checks for placement. 6. Checks for color/amount of residual (if G-tube). 7. Administers feeding appropriately with infection control practices in mind. 8. Documents per site protocol.			

NAME	SS # (last 4 digits)	TITLE
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RN EVALUATOR	SITE	DATE
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**CLINICAL COMPETENCY:
GASTROSTOMY TUBE MED ADMINISTRATION
PART II**

The RN/LPN noted below has completed training in the G-tube curriculum and must now demonstrate clinical competency.

INSTRUCTIONS

The supervising RN at the residence or day program will evaluate this task for one or more consumers at the site, at the discretion of the RN.

All items must be checked YES, NO or N/A for attainment of the competency.

All attempts at attainment are to be documented.

	YES	N/A	NO
1. Follows facility process to determine current medication order.			
2. Washes hands and follows infection control standards throughout.			
3. Gathers necessary equipment including syringe, tap water, gloves.			
4. Explains procedure to consumer and provides privacy.			
5. Positions consumer with head elevated or as prescribed.			
6. Examines G-tube site for excoriation, leakage, drainage or any signs of infection.			
7. Observes the 5 rights of medication administration including right consumer, right med, right dosage, right time, and right route.			
8. Reads the label three times before administration.			
9. Pours accurate dosage. For liquids, properly measures using adapta caps or syringes when applicable.			
10. Uses process that identifies medication up to the point of administration.			
11. Removes plug and clamp from G-tube.			

<p>12. Attaches piston syringe without plunger to G-tube and instills 30-60ml of warm water into syringe allowing gravity flow</p> <p>13. Instills medication and allowed gravity flow. Places water in med cup that held medication and instills, insuring that all med in cup has been administered.</p> <p>14. Flushes with at least 5 ml tap water between all medications.</p> <p>15. Flushes with at least 30-60ml water after all meds are given.</p> <p>16. Detaches piston syringe, replugs and reclaims G-tube as appropriate.</p> <p>17. Repositions consumer per plan of care.</p> <p>18. Cleans or disposes of syringe per established protocol.</p> <p>19. Keeps consumer in upright position for one hour following med administration or per plan of care.</p> <p>20. Records medication administration on MAR/Cardex.</p> <p>21. If controlled drug was administered, documents appropriately.</p> <p>22. Knows desired effects and side effects of medications administered.</p> <p>23. Periodically and/or as indicated, documents consumer's response to drug therapy, information about G-tube site.</p>			
NAME	SS # (last 4 digits)	TITLE	
RN EVALUATOR	SITE	DATE	

MEMO TO: Registered Nurse
FROM: HIM Department
DATE:
SUBJECT: Nursing-Related Documents

The HIM Department recently received nursing-related information on consumer(s) residing in your house/one of your houses. After examination of those documents it was noted that they are not part of the consumer's clinical record. Due to this, the following documents are being returned to you:

- Record of Controlled Substance Administered (keep 7 years)
- Controlled Substance Continuous Count Record (keep 7 years)
- Cumulative Medication Record – *Eastern Region Only* (keep 7 years)
- Individual Client Drug Record (keep 7 years)
- Medication Disposal Record (keep 7 years)
- **Specific Medication Information Sheets (keep 7 years)
- Drug Information Sheets (keep 7 years)
- Medication Transfer Record (keep 7 years)

** This does not apply to the Western Region since scripts are taped/stapled to the back of the form. This is the only non-clinical nursing document that will be filed in the clinical record due the attachment of a clinical record document.

These forms are tracking and monitoring tools for utilization/administrative purposes and should remain on site when the purged consumer clinical record is sent to the HIM Department. Once these documents have reached their retention period they are to be shredded at the site. **Do not** send them to the HIM Department.

Please note that when a consumer is discharged from the DDSO or expires these documents are to be retained on site.

If you have any questions/concerns or would like further clarification, please contact [REDACTED]

Thank you for your assistance in this matter.



Article 16 Clinic at Fairlakes
6007 Fair Lakes Rd., Suite 400
E. Syracuse, NY 13057
Phone: (315) 473-2957
Fax: (315) 234-5745

Article 16 Clinic at Rome
200 W. Dominick Street
Rome, NY 13440
Phone: (315) 339-6536
Fax: (315) 281-0080

EXPOSURE TO TUBERCULOSIS (TB)

Dear parent or guardian of _____, Date of birth _____, per NYS regulations, I am asking that you inform the Article 16 Clinic staff if this child has been exposed to any person who has TB.

If the child has not been exposed to TB up until now, but is exposed in the future, please let us know immediately.

If we have no response from you, we will interpret this to mean that the child has not been exposed, or that you are not aware of any exposure.

Thank you for your help,

Sincerely,

Director, Article 16/HRBC

Copy received by _____ on _____
(parent/guardian) (Date)

Developmental Disabilities State Operations Office 2

Counties Served: Broome, Cayuga, Chenango, Cortland, Delaware, Herkimer, Lewis, Madison, Oneida, Onondaga, Oswego, Otsego, Tioga and Tompkins
(Broome and Central New York DDSOs)

CONSULTATION REPORT

NAME: (Last) (First) (MI)			Consulting Service:
ADDRESS:		ADDRESS:	PHONE#
DATE OF BIRTH:	GENDER:	WEIGHT:	DATE/TIME OF APPOINTMENT:

PRESENT MEDICAL CONCERNS/REASON FOR APPOINTMENT:

--

ALLERGIES :

PRESENT MEDICATIONS

Name, title and date of person completing consult

Name, title and date of person reviewing consult

Report (FINDINGS, DIAGNOSIS, RECOMMENDATIONS, NEW/RE-ORDERED MEDICATIONS):

--

Signature

Date

Next Appointment & Time

Reason

Clinical Notification _____

Staff Assisting Individual

**State of New York
Department of Health**

**Nonhospital Order Not to Resuscitate
(DNR Order)**

Person's Name _____

Date of Birth ___ / ___ / ___

Do not resuscitate the person named above.

Physician's Signature _____

Print Name _____

License Number _____

Date ___ / ___ / ___

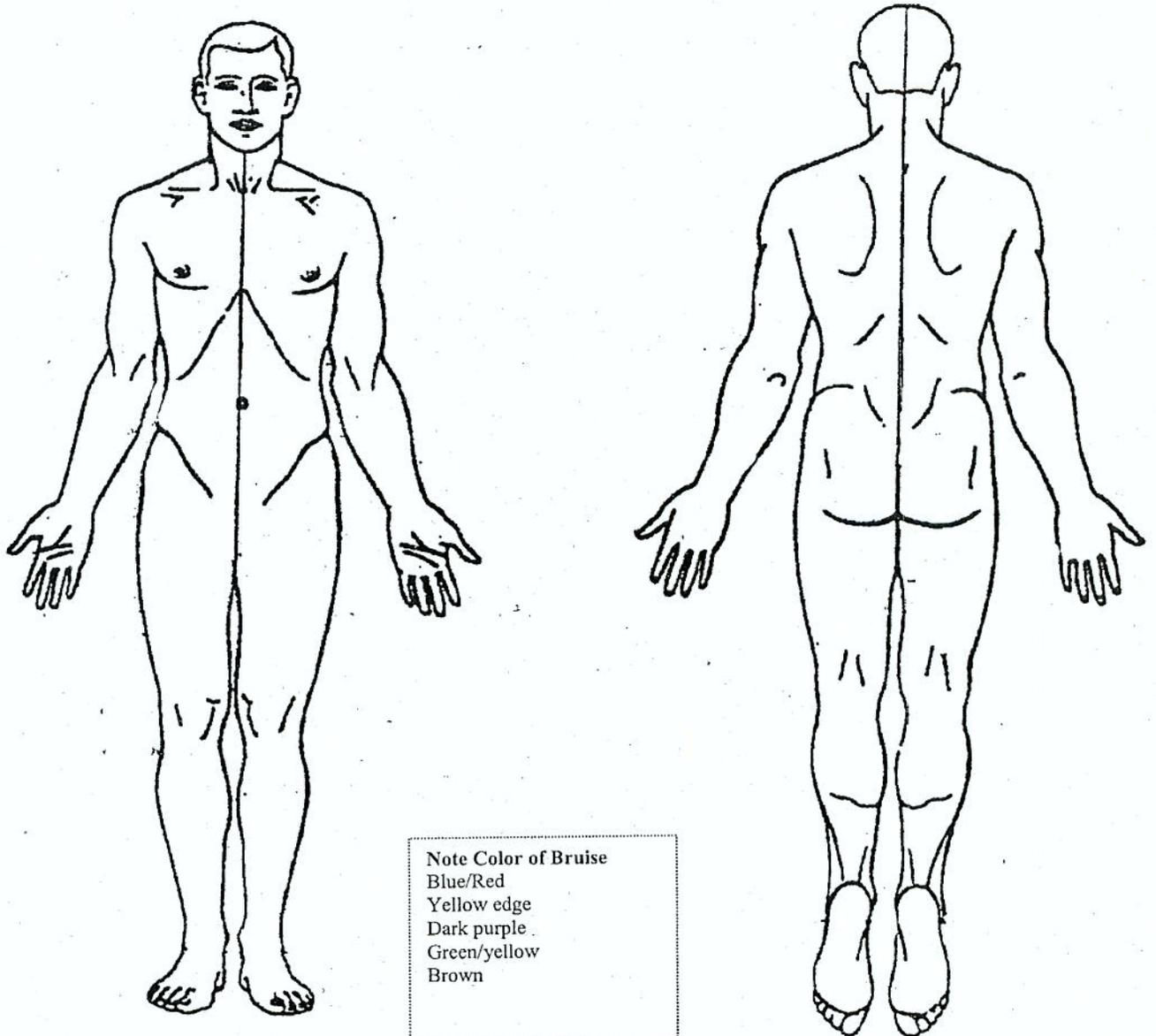
It is the responsibility of the physician to determine, at least every 90 days, whether this order continues to be appropriate, and to indicate this by a note in the person's medical chart. The issuance of a new form is NOT required, and under the law this order should be considered valid unless it is known that it has been revoked. This order remains valid and must be followed, even if it has not been reviewed within the 90-day period.

Consumer Name:	Date:	Time:
		am/pm

Reason for Body Check (check all that apply):

Allegation of Abuse
 Injury
 Other: Reason _____

Directions: Body charts should be completed anytime a reportable injury occurs, or when an Allegation of Abuse is filed that may involve either an injury or other sign of mistreatment. If a body check is being conducted as a result of an Allegation of Abuse, staff uninvolved in the matter should complete the body check whenever possible. Notations/Descriptions can be made in the space provided below. Note location, size, and color of mark(s). Notations can be made on or beside the figure. Additional comments can be written on the reverse side of the form if necessary.



Signature and Title of all staff completing form:

Printed Name:	Signature:	Title:
Printed Name:	Signature:	Title:

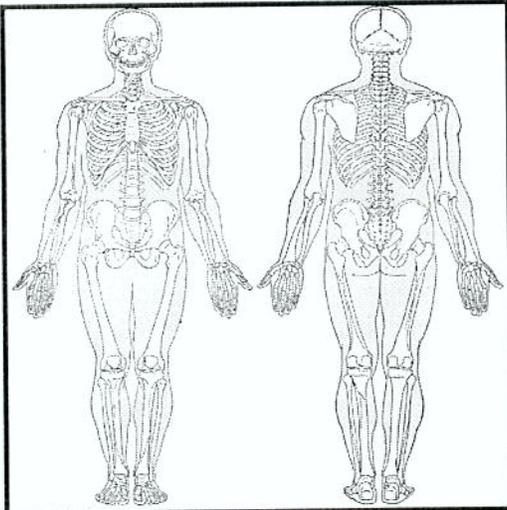
CNY Development Disabilities Office – Routine Physical & Health Care Form

Name: _____ DOB: _____ Physical Date: _____
 Allergies: _____

Interim Medical History since last _____

Baseline Vital Signs:
 Weight: _____ Height: _____ Temp: _____ BP: _____ Pulse: _____ Resp: _____

Immunizations: Last TB	_____ (Date)	_____ (Result)	<input type="checkbox"/> Negative <input type="checkbox"/> Positive (Interpretation)
Tetanus/Diphtheria:	_____ (Date)	_____ (Booster/date)	Tdap: _____ (Date)
Hepatitis B Series:	<input type="checkbox"/> Yes <input type="checkbox"/> No _____ (Dates Given)		
Pneumovax:	_____ (Date)	_____ (Booster)	Influenza _____ (Date) Zoster _____ (Date)
Other:	_____		



Mark on drawing:

Reflex (+)
 Pain (circle)
 Discoloration (d)
 Scoliosis (s)
 Kyphosis (k)

Upper / Lower Extremities:

L	R	L	R	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Strength
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Color
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Edema
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Varicosities
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Clubbing
Other _____				

*Body chart by permission from www.prohealthsys.com

CNY Development Disabilities Office – Routine Physical & Health Care Form

Name: _____

Weight Gain _____ Lbs. Weight Loss _____ Lbs.
 Diet Consistency: Whole 1" pieces 1/2" pieces 1/4" pieces Ground Puree Other : _____
 Liquid Consistency: Thin Nectar Honey Pudding
 Other: Low Calorie _____ High Fiber Low Fat No added salt Increase liquids
 Dietary Recommendation _____
 Enteral (Tube) Feeding: via G-Tube via J-tube

Skin <input type="checkbox"/> WNL <input type="checkbox"/> Scars <input type="checkbox"/> Moles <input type="checkbox"/> Ulcers <input type="checkbox"/> Rash _____	Head and Neck <input type="checkbox"/> WNL <input type="checkbox"/> Hair <input type="checkbox"/> Shape <input type="checkbox"/> Masses <input type="checkbox"/> TMJ <input type="checkbox"/> Thyroid <input type="checkbox"/> Lymph _____	L R Eyes <input type="checkbox"/> WNL <input type="checkbox"/> <input type="checkbox"/> Pupils <input type="checkbox"/> <input type="checkbox"/> Sclera <input type="checkbox"/> <input type="checkbox"/> Conjunctiva <input type="checkbox"/> <input type="checkbox"/> Lids _____	L R Ears <input type="checkbox"/> WNL <input type="checkbox"/> <input type="checkbox"/> Canal <input type="checkbox"/> <input type="checkbox"/> Cerumen <input type="checkbox"/> <input type="checkbox"/> Hearing Loss _____	L R Nose <input type="checkbox"/> WNL <input type="checkbox"/> <input type="checkbox"/> Nares <input type="checkbox"/> <input type="checkbox"/> Mucosa <input type="checkbox"/> <input type="checkbox"/> Discharge <input type="checkbox"/> <input type="checkbox"/> Septum _____
Mouth/throat <input type="checkbox"/> WNL <input type="checkbox"/> Tongue <input type="checkbox"/> Tonsils <input type="checkbox"/> Teeth <input type="checkbox"/> Edentulous <input type="checkbox"/> Dentures <input type="checkbox"/> Gums <input type="checkbox"/> Drooling <input type="checkbox"/> Lips _____	Lungs <input type="checkbox"/> WNL <input type="checkbox"/> Symmetry <input type="checkbox"/> Wheezing _____	Mobility <input type="checkbox"/> WNL Ambulatory with: <input type="checkbox"/> Cane <input type="checkbox"/> Walker <input type="checkbox"/> Uses wheelchair _____	Heart <input type="checkbox"/> WNL <input type="checkbox"/> Rhythm <input type="checkbox"/> Murmur _____	L R Breasts <input type="checkbox"/> WNL <input type="checkbox"/> <input type="checkbox"/> Symmetry <input type="checkbox"/> <input type="checkbox"/> Discharge <input type="checkbox"/> <input type="checkbox"/> Lumps/Nodes <input type="checkbox"/> <input type="checkbox"/> Pain _____
Abdomen <input type="checkbox"/> WNL <input type="checkbox"/> Sounds <input type="checkbox"/> Masses <input type="checkbox"/> Tenderness <input type="checkbox"/> Hernia _____	Genitalia <input type="checkbox"/> WNL Male: <input type="checkbox"/> Undescended Testes <input type="checkbox"/> Hypospadias Female <input type="checkbox"/> WNL _____	Rectal <input type="checkbox"/> WNL <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Prostate <input type="checkbox"/> Masses <input type="checkbox"/> Pilonidal _____	Recommended Preventative Screening: (Per NYS Task-Force Guidelines): <input type="checkbox"/> Oral Cancer Screening <input type="checkbox"/> C-Spine X-ray <input type="checkbox"/> Pap Smear <input type="checkbox"/> Colonoscopy <input type="checkbox"/> Thyroid <input type="checkbox"/> Bone Density <input type="checkbox"/> EKG <input type="checkbox"/> LabWork _____	

See page 3

Please fax to 315-339-8089

**SCRIPT(S) NEEDED
FROM**

Dr. [redacted] / Dr. [redacted] / Dr. [redacted] / Dr. [redacted] /
Lawrence [redacted]

(please circle which medical staff)

Name of Site: _____ Date of Request _____

Address: _____ Phone #(315) _____
_____ Fax# (315) _____

Pharmacy: _____ Pharmacy Phone _____

Person requesting script: _____

- Mail to house
- Site to pick up scripts

Individual's Name: _____ Date of Birth: _____

Rx: (please be sure to include dosage, frequency, etc. – please print)

**Please give a seven day notice when requesting scripts
Please attach MARS**

NYS Office for People with Developmental Disabilities

AUTHORIZATION

for Diagnostic Assessment Services

Child's Name: _____ DOB: _____

INITIAL REVIEW

I authorize an assessment for the above child inclusive of:

Occupational therapy

Physical therapy

Speech/language

Social work

Psychology

Medical

Psychiatry

Nurse Practitioner

Diagnosis: 315.9 (all undiagnosed children) other _____

Authorized by _____

Date

M.D.

M.D.

M.D.

****Part 679.3 (q) states that "All treatment plans and referrals for services, regardless of source, shall be reviewed and approved by the medical director or other designated physician/dentist.

OPWDD Administrative Memorandum #2005-01 indicates that "all clinic treatment plans shall be based on a current and written individualized, clinical examination, assessment and/or evaluation. 7/10/10

DIABETIC RECORD

Name: _____ Residence: _____ C#: _____ DOB: _____ Month/Year: _____

INSULIN ADMINISTRATION	DATE	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
	Amt Given																																
	Time																																
	Site																																
	Initial																																

INSULIN ADMINISTRATION	DATE	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
	Amt Given																																
	Time																																
	Site																																
	Initial																																

INSULIN ADMINISTRATION	DATE	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
	Amt Given																																
	Time																																
	Site																																
	Initial																																

INSULIN ADMINISTRATION	DATE	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
	Amt Given																																
	Time																																
	Site																																
	Initial																																

Blood Sugar	Time																															
	Reading																															
Blood Sugar	Time																															
	Reading																															
Blood Sugar	Time																															
	Reading																															
Blood Sugar	Time																															
	Reading																															

SLIDING SCALE COVERAGE				Site Code				Initial Code			
Blood Sugar Range	INSULIN AMT	Blood Sugar Range	INSULIN AMT	1	Left Arm	6	Right Abdomen				
to	to	to	to	2	Right Arm	7	Left Buttock				
				3	Left Leg	8	Right Buttock				
				4	Right Leg	9	Left Waist				
to	to	to	to	5	Left Abdomen	10	Right Waist				

CONTROLLED PRESCRIPTION LOG

Name: _____ Date-of-Birth: _____

Address: _____

Phone Number: _____

Psychologist: _____ Phone Number: _____

Support Contact: _____ Phone No.: _____ Fax No.: _____

Medication: _____

Special Instructions: _____

Pharmacy Name/Address: _____

Pharmacy Phone Number: _____ Pharmacy Fax Number: _____

******* ALL PRESCRIPTIONS ARE MAILED DIRECTLY TO THE ABOVE NAMED PHARMACY*******

Prescribing Doctor: 

Date R_x Written: _____ Date R_x Mailed: _____

Next Appointment & Time

Reason:

Staff assisting consumer

CONSULTATION REPORT

NAME: (Last) (First) (MI)			Consulting Service:
ADDRESS:		ADDRESS:	PHONE#
DATE OF BIRTH:	GENDER:	WEIGHT:	DATE/TIME OF APPOINTMENT:

PRESENT MEDICAL CONCERNS/REASON FOR APPOINTMENT:

--

ALLERGIES :

PRESENT MEDICATIONS

Name, title and date of person completing consult

Name, title and date of person reviewing consult

Report (FINDINGS, DIAGNOSIS, RECOMMENDATIONS, NEW/RE-ORDERED MEDICATIONS):

--

Signature

Date

Next Appointment & Time

Reason

Clinical Notification _____

Staff Assisting Individual

CNYDSO HEAD INJURY PROTOCOL

Head, neck or back injuries may be life-threatening and should be suspected in the following situations:

- A. Involved in a significant motor vehicle crash
- B. Fall from a height greater than standing height
- C. Any fall while in a wheelchair
- D. A fall or injury that results in any **SIGNALS of possible head, neck or back injury including:**
 - ◆ Change in consciousness
 - ◆ Loss of consciousness
 - ◆ Severe pain or pressure in the head, neck or back
 - ◆ Tingling, weakness or loss of sensation in extremities
 - ◆ Partial or complete loss of movement in any body part including the hands, fingers, feet or toes
 - ◆ Depressions on the head or over the neck and back
 - ◆ Blood or other fluids coming from the ears or nose
 - ◆ Heavy external bleeding of the head, neck or back
 - ◆ Seizures following a fall or injury
 - ◆ Nausea or vomiting following a fall or injury
 - ◆ Loss of balance following a fall or injury
 - ◆ Bruising of the head, especially around the eyes and behind the ears.
 - ◆ Slurred speech following a fall or injury
 - ◆ Report of neck or back pain

If one or more of the above SIGNALS are present, call 911 and provide first aid. Following evaluation and/or treatment by a Health Care Provider notify the supervising RN or RN-On-Call and implement the Head Injury Checklist.

For *soft tissue injuries* including injuries to the face, head, neck or back which result in bruises or bumps. Notify the RN or RN-On-Call and implement the Head Injury Checklist.

Follow behavior management plan guidelines and/or PONS where indicated for SIB (self-injurious behavior) to the face, head or neck.



□ Article 16 Clinic at Fair Lakes
6007 Fair Lakes Rd. Suite 400
E. Syracuse, NY 13057
(315) 234-5730 x363
Fax: (315) 234-5745

□ Article 16 Clinic at Rome
200 W. Dominick St.
Rome, NY 13440
(315) 339-6536 x3162
Fax: (315) 339-8089

Date: _____

RE: _____

DOB: _____

Dear Primary Care Provider: _____

The Interdisciplinary Team recommends that _____

receive the following services through the Article 16 Clinic:

____ Psychiatry

____ Audiology

____ Physical Therapy

____ Occupational Therapy

____ Nutrition

____ Speech

____ Psychology

____ Other _____

A referral for Article 16 clinic services is needed at the time of the initial request and annually thereafter. Please indicate your approval for these services by signing below and please return this form by fax to:

_____. The fax number is: _____.

Primary Care Provider's Signature

Date

Developmental Disabilities State Operations Office 2

Counties Served: Broome, Cayuga, Chenango, Cortland, Delaware, Herkimer, Lewis, Madison, Oneida, Onondaga, Oswego, Otsego, Tioga and Tompkins
(Broome and Central New York DDSOs)

Clinical/Surrogate Breast Examinations

CNY DSO recognizes the importance of preventative health care for all individuals. Breast cancer screenings follows the Preventative Health Care Screening Guidelines for Individuals Aging with Intellectual. Developmental Disabilities 2009:

“Breast cancer screening- preventative exam: mammogram-Age 40+ with or without Clinical Breast Exam every 1-2 years at the discretion of the MD (consider earlier if family history.) For women who have a strong family history or are difficult to examine with a mammogram, consider genetic testing for the BRAC-A gene.”

Breast cancer facts*: Early breast cancer usually doesn't cause symptoms. As the tumor grows, it can change how the breast looks or feels. The common changes include:

- A lump or thickening in or near the breast or in the underarm area
- A change in the size or shape of the breast
- Dimpling or puckering in the skin of the breast
- A nipple turned inward into the breast
- Discharge (fluid) from the nipple, especially if it is bloody
- Scaly, red or swollen skin on the breast, nipple or areola (dark area of skin at the center of the breast). The skin may have ridges or pitting so that it looks like the skin of an orange.

Each woman who is capable of **self-breast exam** should be taught by an MD, NP or other experienced clinical staff. The supervising RN should check periodically to ensure that these self breast exams are being done and there are no positive findings.

A **clinical breast exam** is performed by an MD, NP or other experienced clinical staff. This involves looking at and feeling the breast and underarms for any changes or abnormalities (such as a lump). Breasts should be checked while the woman is sitting up and lying down.

Surrogate breast exams are exams done by trained RNs or LPNs. It is important to perform these monthly exams about the same date each month and to record any findings. Positive findings of potential breast cancer should be promptly referred to a clinician. Surrogate breast exam training is provided by CNY DSO Nurse Practitioners.

Ultrasounds in place of a mammogram for individuals who are unable to have a mammogram are NOT routinely clinically indicated. Each case should be individually considered by the practitioner.

Alternatives when mammography is not possible:

- 1- 2 clinical breast exams performed (at the annual exam and at the annual GYN exam)
- 2- a surrogate breast exam is performed monthly.

*from Medicinenet.com
12/2010

TOPIC: H1456	MEDICATION ADMINISTRATION COMPETENCY CHECKLIST	CLINICAL
--------------	--	----------

NAME: _____ SITE: _____ SS# _____
Last 4 digits

For initial certification only

FINAL DATE MED COURSE: _____ TEST MARKS: 1) _____ 2) _____

CLINICAL DATES: 1) _____ 2) _____ 3) _____

INITIAL CERTIFICATION/RECERTIFICATIONS

I have reviewed the components of the medication competency checklist with this RN and understand the Central New York DSO Medication Policies and Procedures. I am comfortable and confident in the administration of Medications at this/these residence(s).

Date	Staff Signature	RN Signature	Residence(s)

INSTRUCTIONS

Clinical evaluations must be successfully completed for initial and annual AMAP certification. The clinical evaluations shall take place during a regularly scheduled time for medication administration and shall include medication passes for all consumers scheduled to receive medications at that time at the location where the staff is permanently assigned. The R.N. shall document ongoing medication administration observations on this form. The original document is to be kept by the supervising RN. If an AMAP transfers to a new site, the form must be forwarded to the new supervising RN.

Initial Certification:

The staff must complete three **errorless** clinical evaluations to complete the AMAP certification process. Following the successful completion of the clinical evaluations, a copy of the entire document and the 811 is sent to Staff Development.

Recertification:

During annual recertification, the AMAP must complete one errorless medication administration evaluation to be recertified as an AMAP. A copy of the 811 is sent to Staff Development.

If staff attains the competency, the R.N. will √ the box; if staff is unable to attain the competency, the R.N. will place an Inc. (Unable to attain competency) in the box. If any items do not apply to medication administration at the site, the R.N. will place a Rev in the box and review the information with the staff person.

Key	
√	Staff competency
INC	Unable to attain competency
REV	Reviewed information

Dates:									
Site:									
Security:									
Keys on person or in locked box.									
Medication cabinet and room locked when out of area.									
Does not leave medications unattended.									
Preparation:									
Washes hands and ensure clean work area.									
Concentrates entire attention on preparing and administering medications—does not allow self to be distracted.									
Assembles necessary equipment/supplies for medication administration.									
Follows protocol for the counting and documentation of controlled substances.									
Follows facility process to determine current medication orders.									
Knows desired effects and side effects of medication administered.									

Dates:									
Site:									
Knows skill level of consumer's self-medication status and supports needed for medication administration.									
Checks for drug allergies.									
Vital signs checked and documented as indicated.									
Administers medications with consideration for dietary and fluid requirements.									
ADMINISTRATION:									
Read medication from record and compare to pharmacy label. <ul style="list-style-type: none"> • When removing from medication cabinet • Before pouring the medication • Before returning the medication to the cupboard. 									
Pours accurate dose of medication <ul style="list-style-type: none"> • Liquids _____ • Tablets/capsules - adequate liquids administered as part of the process _____ • Sublingual _____ • Inhalation _____ • Instillation _____ • Topical _____ • Transdermal _____ • Suppository – (vaginal)/(rectal) _____ 									

Dates:									
Site:									
Pours and administers medication and documents administration for one consumer at a time.									
Utilizes the 5 rights for administration. Right consumer Right medication Right dosage Right time/ frequency Right route									
Shows positive regard for consumer during medication administration process—explains procedure to consumer.									
Ensures consumer is in upright position unless otherwise indicated.									
Remains with consumer until after oral medication is taken and ensures that consumer has swallowed medications.									
After administration, documents initials immediately on the MAR. Legend to include signature and job title.									
When applicable, completes the record of controlled substances.									

Dates:									
Site:									
Describes process for reporting to R.N. if medications cannot be administered as prescribed.									
Washes hands between consumers.									
Cleans medication area and resupplies the area as necessary.									
Describes and/or documents the process for disposal of contaminated medications.									
Describes and/or documents the process for receiving medications from the pharmacy.									
Is knowledgeable regarding storage requirements for medications.									
OBSERVATION AND REPORTING									
Reviewed signs and symptoms of illness specific to consumers at that site.									
Reviewed processes to notify RN of signs and symptoms of illness.									
Reviewed RN on-call system.									
Reviewed procedure/protocol for PRN medication.									
Reviewed updates on medications and updates on policy									
Reviewed plans of nursing service.									

DATE/COMMENTS: _____



Article 16 Clinic
6007 Fairlakes Road Suite400
E. Syracuse, NY 13057
(315) 234-5730 X363
Fax: (315) 234-5745

Date: _____

RE: _____

DOB: _____

To Whom It May Concern:

Due to recent changes in the Article 16 Clinic procedures, we now require a physician’s referral for any services that are provided through the clinic. Attached is our referral request form that is marked for all of the services that have been requested and are provided or will be provided for the individual you serve. Please have the primary care physician sign the form and return to the Clinic so we can begin or continue to provide services to the individual.

A referral form will be required on annual basis so it is recommended that the continued need for each of these services be reviewed at the time of the ISP review.

Thank you for your prompt attention to this matter and your continued assistance in meeting the needs of the individuals we serve.

Sincerely,

[Redacted Signature]

Article 16 Clinic Treatment Coordinator

Developmental Disabilities State Operations Office 2

Counties Served: Broome, Cayuga, Chenango, Cortland, Delaware, Herkimer, Lewis, Madison, Oneida, Onondaga, Oswego, Otsego, Tioga and Tompkins
(Broome and Central New York DDSOs)

CNYDSO Clinic Physician Approval

Date of Request: [REDACTED]

Consumer: [REDACTED]

Tab ID: [REDACTED]

Date of Birth: [REDACTED]

Residence: [REDACTED]

Address: [REDACTED]

Contact: [REDACTED]

Treatment Coordinator: [REDACTED]

Case Manager: [REDACTED]

Phone: [REDACTED]

Clinician: [REDACTED]

Tab ID: [REDACTED]

Presenting Problem:

[REDACTED] is a gentleman with mild intellectual disabilities and an unspecified hearing loss. [REDACTED] was last seen on [REDACTED] when it was recommended that [REDACTED] return for an evaluation in 12-15 months.

Clinic Services Authorized:

AUD Audiology Services

Physician Signature: _____

Date: _____

CNYDSO APPROVED ONGOING SERVICE PLAN

Consumer: [REDACTED] Tabs ID: [REDACTED] Date of Birth: [REDACTED]
Provider: [REDACTED] Address: [REDACTED]
Case Manager: [REDACTED] Phone: [REDACTED]
Treatment Coordinator: [REDACTED]

Services Authorized:

Residential Tx. Code:

PST Psychiatry Services

Treatment Type: Psychiatry Clinician: [REDACTED]

ICD Code: [REDACTED] Diagnosis: Autistic Disorder, current or active state

Initial Contact: [REDACTED] Effective Date: [REDACTED] Revised: [REDACTED]

Face to Face Service: Psychiatric evaluation and medication management.

Anticipated Goal(s): Reduction in anxiety; elimination of insomnia & assault; reduction of tantrums and self-injurious behavior.

Frequency of Service: q 6 months & prn Duration: Ongoing

Method of Evaluation: Clinica interview; staff reports; data sheets.

Physician Signature: _____

Date: _____

CNYDSO Clinic Assessment Findings

Date of Request: [REDACTED]

Consumer: [REDACTED]

Tab ID: [REDACTED]

Date of Birth: [REDACTED]

Residence: [REDACTED]

Address: [REDACTED]

Contact: [REDACTED]

Treatment Coordinator: [REDACTED]

Case Manager: [REDACTED]

Phone: [REDACTED]

Assigned Clinician: [REDACTED]

Tab ID: [REDACTED]

Presenting Problem:

[REDACTED] is a gentleman with mild intellectual disabilities and an unspecified hearing loss. [REDACTED] was last seen on [REDACTED] when it was recommended that he return for an evaluation in 12-15 months.

Services Authorized:

AUD Audiology Services

Date of Evaluation: _____

EVALUATION:

(YOU MAY ATTACH A COPY OF YOUR EVALUATION IN LIEU OF COMPLETING THIS SECTION)

This Section Must Be Completed By Clinician:

DIAGNOSIS RELATED TO THIS EVALUATION: _____

DO YOU INTEND TO PROVIDE ONGOING DIRECT CLINICAL SERVICES BASED ON THIS EVALUATION?

YES _____ *If yes, please complete the next page.*

NO _____

Clinician Signature and Title: _____

Date: _____

Medical Director Signature: _____

Date: _____

CNYDSO Clinic Ongoing Service Request

Date of Request: [REDACTED]

Consumer: [REDACTED]

Tab ID: [REDACTED] Date of Birth: [REDACTED]

Residence: [REDACTED] Address: [REDACTED]

Contact: [REDACTED] Treatment Coordinator: [REDACTED]

Case Manager: [REDACTED] Phone: [REDACTED]

You May Use the All-In-One Version of this Form in Lieu of Completing the Below. If so, Please Attach a Hard Copy of the Completed All-In-One Form When You Return This to Your Treatment Coordinator

CL Code(s) Requested: _____

Recommended Face to Face (Billable) Service You Will Provide For This Person:

Location Where Provided: _____

Residential Tx. Code: _____

Service Frequency: _____

Duration of Service: _____

(e.g. Weeks, Months, Ongoing, etc.)

Anticipated Goal(s): *(Please State In Measurable Terms)*

Method of Evaluating Goal Progress: *(e.g., Direct Observation, Data Sheets, Staff Reports, etc.)*

Clinician Signature and Title: _____

Date: _____

CNYDSO CLINIC REVIEW

Consumer: [redacted] Tabs ID: [redacted] Date of Birth: [redacted]
Provider: [redacted] Address: [redacted]
Case Manager: [redacted] Phone: [redacted]
Treatment Coordinator: [redacted]

Services Authorized:

Residential Tx. Code:

PST Psychiatry Services

Treatment Type: Psychiatry

Clinician: [redacted]

ICD Code: [redacted] Diagnosis: Autistic Disorder, current or active state

Initial Contact: [redacted] Effective Date: [redacted] Revised: [redacted]

Face to Face Service: Psychiatric evaluation and medication management.

Anticipated Goal(s): Reduction in anxiety; elimination of insomnia & assault; reduction of tantrums and self-injurious behavior.

Frequency of Service: q 6 months & prn Duration: Ongoing

Method of Evaluation: Clinica interview; staff reports; data sheets.

6 MONTHS (SEMI-ANNUAL REVIEW)

12 MONTHS (ANNUAL REVIEW) I have reviewed the service outlined and authorize the continuation of this plan.

MD Signature _____ Date _____

SUMMARIZE PROGRESS

Last Renewal Date:

WHAT DO YOU RECOMMEND CONCERNING THIS TREATMENT PLAN:

CONTINUE PLAN WITHOUT CHANGES: _____ DISCONTINUE: _____

CONTINUE PLAN WITH THE FOLLOWING REVISIONS: _____

Clinician Signature and Title: _____ Date: _____

Clinic Services Coordinated: _____ Date: _____

CHOKING PREVENTION TRAINING LINK

<http://www.opwdd.ny.gov/node/1948>

EARLY INTERVENTION TABLE OF CONTENTS

SECTION I: INTAKE DOCUMENTS

- REGISTRATION (725)
- IPP-4 (DIAGNOSTIC REPORTING FORM)
- INDIVIDUAL BILL OF RIGHTS
- EMERGENCY CONTACT FORM
- EXPOSURE TO TUBERCULOSIS FORM
- NOTICE OF PRIVACY PRACTICES
- CONSENT TO RELEASE
- FAMILY NEEDS ASSESSMENT FORM
- MEDICAL STUDENT/INTERN PARTICIPATION FORM
- SUBROGATION FORM - ?
- INSURANCE FORMS (NYEIS) - ?
- RECORD ACCESS LOG

SECTION II: AUTHORIZATIONS FOR ASSESSMENTS /TREATMENTS

- SOCIAL HISTORY
- INDIVIDUALIZED FAMILY SERVICE PLAN
- NYEIS HOME PAGE
- SCRIPT FOR PRIMARY CARE PHYSICIAN

> outside source

SECTION III: ASSESSMENT/TREATMENT INFORMATION

- EVALUATIONS (HRB CLINIC & OUTSIDE AGENCIES)
- SUMMARY FORM FOR MULTIDISCIPLINARY EVALUATIONS
- NYEIS MULTIDISCIPLINARY EVALUATION SUMMARY
- TREATMENT NOTES - ?
- ANNUAL/SEMI-ANNUAL CLINIC TREATMENT COORDINATOR NOTES - ?

SECTION IV: NYEIS BILLING

- VERIFICATION OF EVALUATION
- NYEIS BILLING FORMS/ SERVICE AUTHORIZATION FORM
- CONSENT TO TREAT FORM (THERAPIES)

SECTION V: MEDICAL

- ALLERGY INFORMATION SHEET
- MEDICAL RECORDS (HOSPITAL/PRIMARY CARE/SPECIALISTS) - outside
- MEDICAL RELEASE FORMS - outside

SECTION VI: CORRESPONDENCE

- COMMUNICATION TO AND FROM HIGH RISK BIRTHS CLINIC STAFF
- TRACKING TOOL

PURPOSE	<input type="checkbox"/> Screening	<input type="checkbox"/> Registration	<input type="checkbox"/> Readmission
	<input type="checkbox"/> Transfer	<input type="checkbox"/> Demographic Data Change	<input type="checkbox"/> Diagnostic Update

CE-1 Registration Screen

1. Name (Last, First, M.I.)(Please Print)		2. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		3. Date of Birth / /		4. Registration /Screen date / /	
5. County of Residence		6. County of Interest		7. Current Address		Telephone # () -	
8. Residence Type		9. Social Security # - -		10. CIN Number		12. Medicare #	
13. Ethnicity Race		14. Hispanic Origin <input type="checkbox"/> Yes <input type="checkbox"/> No		15. U.S. Citizen <input type="checkbox"/> Yes <input type="checkbox"/> No		16. Country of Birth	
17. Referral Source		18. Marital Status		19. Religion Code		20 Religious Denomination	
21 Primary Disability		22. Secondary Disability		23. Special Pop. Indicator		24. Spoken Language	
25. Non-verbal Lang. Code		26. Education Code		27. School District			

28. Registration Comments:

29. Understood Language:		30. Wheelchair: <input type="checkbox"/> Yes <input type="checkbox"/> No		31. CE2 :Add to Program: If accepted for Services:			
				DATE: / /			
				Program Name			
				Program Code			

32. CE 7 – 9: Diagnostic Information:

Diagnosis date: / /		Clinician Signature:					
Primary Diagnosis:				Code:			
Etiology:				Code:			
Other Significant Diagnosis:				Code:			
Date of Test: / /		Test Type:		Test Results:			
Source of Diagnostic Information:							

33. CE10: Legal Screen:

Legal Status:				Legal Status Code:			
Effective Date: / /				Expiration Date: / /			

34. CE11: Correspondence Screen:

Correspondent Type: _____		Status: _____		Relationship: _____			
Primary Name:				Secondary/Attention Name:			
Address:				City:		State:	Zip:
Work Phone: () -				Home Phone: () -		Mail Status _____	

35. CE16: Facility Consecutive

<p>OMR/DD 725 (3/95) TABS REGISTRATION/ SCREENING FORM (Send Completed form to TABS Data entry person for data entry processing)</p>		# 0233					
		Completed By: _____ Title: _____ Date: _____ Data Entered By: _____ Date: _____					

1. NAME (LAST) (FIRST) (M.I.)	2. C-NUMBER	3. DATE OF BIRTH	4. GENDER
-------------------------------	-------------	------------------	-----------

5. FACILITY NAME	6. FACILITY CODE	UNIT CODE	7. DATE DIAGNOSIS COMPLETED
	[][][][]	[][][]	MO [][] DAY [][] YEAR [][][]

8. TRANSACTION

1 Admission Diagnostic Data 2 Additional Diagnostic Data 3 Medical/Surgical Data 4 Correction/Deletion

9. DIAGNOSIS

PRIMARY _____ [][][][] ENTER PRIMARY CODE
Use codes listed under PRIMARY & OTHER DIAGNOSES on back.

ETIOLOGICAL _____ [][][][] ENTER CAUSE OF PRIMARY DIAGNOSIS
Use codes listed under ETIOLOGICAL DIAGNOSES on back for general categories —Refer to ICD 9CM for specific code.

OTHER _____ [][][][] ENTER all other diagnoses — continue below
Use codes listed under PRIMARY & OTHER DIAGNOSES on back; Refer to ICD 9CM for medical and additional codes.

—ADDITIONAL DIAGNOSES/CODES—

_____ [][][][]	_____ [][][][]
_____ [][][][]	_____ [][][][]
_____ [][][][]	_____ [][][][]

10. SEIZURES *If absent, enter 9. If present, indicate by entering number found to the right of 345. In list of PRIMARY & OTHER DIAGNOSES on the back.*

11. ASSOCIATED CLINICAL INFORMATION

If any of the following are present, enter the corresponding number in the box on the same line. If absent, enter zero.

Loss of previously attained developmental performance (enter 1)

Dysmorphic features (enter 2)

Family history of similar MR/DD disorders (enter 4)

Add and enter total

12. CLINICIAN SIGNATURE

CLINICIAN CODE NUMBER

[][][][][]

13. MOST RECENT IQ TEST

0 None 2 WAIS-R 4 Binet 6 Other (Specify) _____

1 WISC-R 3 WPPSI 5 Leiter 7 Unknown

14. IQ SCORE [][][]

YEAR TESTED [][]

15. MEDICAL-SURGICAL—either facility or outside hospital. Use ICD 9CM for codes.

Date Established	Diagnosis	Procedures
MO [][] DAY [][] YEAR [][][]	[][][][]	[][][][]
[][][][]	[][][][]	[][][][]

16. To **DELETE** previously entered data complete Section A below entering erroneous data you wish deleted.

Date Established	Primary Diagnosis	Etiology	Other Diagnosis	Procedure	Procedure	Seizures	Assoc. Clin. Information
MO [][] DAY [][] YEAR [][][]	[][][][]	[][][][]	[][][][]	[][][][]	[][][][]	[][][][]	[][][][][]
[][][][]	[][][][]	[][][][]	[][][][]	[][][][]	[][][][]	[][][][]	[][][][][]

PRIMARY DIAGNOSES

AUTISM

299.0	Infantile Autism	299.01	Residual
299.00	Active		

CEREBRAL PALSY

343.0	Diplegic	343.8	Other specified infantile cerebral palsy (ataxia atonic, mixed, rigidity, tremor)
343.1	Hemiplegic	343.9	Infantile cerebral palsy, unspecified
343.2	Quadriplegic	333.7	Athetoid cerebral palsy
343.3	Monoplegic		
343.4	Infantile hemiplegia		

EPILEPSY

345.0	Generalized nonconvulsive epilepsy (absences, minor, petit mal, Pykno-epilepsy, akinetic, atonic)	345.5	Partial epilepsy, without mention of consciousness (Jacksonian)
		345.6	Infantile spasms
345.1	Generalized convulsive epilepsy (clonic, myoclonic, tonic, tonic-clonic, grand mal, major)	345.7	Epilepsia partialis continua
		345.8	Other or unspecified forms of epilepsy
345.2	Petit mal status		
345.3	Grand mal status		
345.4	Partial epilepsy, with impairment of consciousness (psychomotor, temporal lobe)		

MENTAL RETARDATION

317.	Mild MR	318.2	Profound MR
318.0	Moderate MR	319.	Unspecified Mental Retardation
318.1	Severe MR		

NEUROLOGICAL IMPAIRMENTS AND OTHER DISABILITIES

314.0 - 314.9	Hyperkinetic Syndrome—Specific delays in development	342.1	Spastic hemiplegia
		342.9	Hemiplegia, unspecified
315.3 - 315.4	(For clients through age 7 only)	369.0 - 369.9	Blindness
237.7	Neurofibromatosis	389.0 - 389.9	Deafness
307.23	Gilles de la Rouette Syndrome	741.	Spina bifida
342.0	Flaccid hemiplegia		

CODING RANGES

ETIOLOGICAL DIAGNOSES • GENERAL CATEGORIES (ICD • 9 • CM)

001-139	Associated with infectious agents (Specify)	710-739	Neuromuscular (Specify)
140-239	Neoplasia (Specify)	740-759	Congenital anomalies and chromosomal abnormalities (Specify)
240-279	Miscellaneous (endocrine, nutritional, genetic, metabolic, social, etc.) (Specify)	760-779	Associated with perinatal period (Specify)
320-326	Additional problems associated with infectious agents (Specify)	800-854	Associated with postnatal trauma (Specify)
		960-999	Associated with intoxicants (Specify)
330	Inherited disorders of glycosphingolipid metabolism, and other genetic disorders (Specify)	742.3	Congenital hydrocephalus
		E800.0-E999.0	Causes of injury or poisoning
331	Hereditary degenerative disorders (Specify)	799.9	Unknown

GENERAL INSTRUCTIONS

(USE BALLPOINT PEN)

1. Complete a Diagnostic Report in duplicate for each client admitted or for each change/update.
2. Complete the Diagnostic Report immediately after the initial face-to-face interview with the client or his correspondent or as soon as Sections 1-14 can be completed.
3. Use form to send in additional information as it becomes available.
4. Additional reports are to be made to add, correct or delete diagnostic information. (When adding a correction, be sure to enter code to be deleted in Section 16.)
5. Use form to report medical/surgical events.
6. Enter the client's name and the client's consecutive number, date of birth, gender, facility name, facility and unit code, and date diagnosis completed.
7. Check appropriate "transaction" box.
8. Refer to ICD 9CM for all precise ETIOLOGY codes and for any diagnostic codes not listed on the back of the form. Up to ten (10) diagnoses may be listed.
9. Enter all available information in the spaces provided.
10. Sign form; enter clinician identification code.
11. Send the yellow copy of the form to the Medical Records Office.
12. File the original copy in the client's record.

INDIVIDUAL BILL OF RIGHTS

High Risk Births Clinic
305 Main Street
Binghamton, NY 13905
Tel: 607-729-1295
Fax: 607-777-9497

The High Risk Births Clinic recognizes its responsibility to provide individuals with quality care. A child and his/her family have the right to:

- Receive services without regard to race, sexual orientation, religion, creed, age, gender, ethnic background, family marital status, national origin, or health condition such as one tested for or diagnosed as having a Human Immunodeficiency Virus (HIV), infection of Acquired Immune Deficiency Syndrome (AIDS), or HIV related illness. There shall be no discrimination or any form of abuses, (including adverse reactions), for these or any other reasons. In addition, confidentiality will be maintained in regard to HIV related information.
- Be treated with consideration, respect and dignity;
- Receive information concerning the child's diagnoses treatment plan and progress in understandable terms;
- Participate in the planning and implementation of the child's treatment plan, and be afforded the opportunity to change the plan or the treating clinician at any time;
- The use of clean and age appropriate toys;
- Confidentiality of all information pertaining to the child and family, including information in the records.
At the HRB Clinic we comply with HIPPA and FERPA regulations. The FERPA policy can be viewed on <http://ecfr.gpoaccess.gov> or if you do not have access to a computer one can be provided to you at your request.
- Receive ample notification of any change in treatment or scheduling as well as the reason for the change,
- Receive reports in a timely fashion and in accordance with Early Intervention guidelines.
- Freedom from smoking, physical restraints, psychological or sexual abuse, or from any punishment.
- Access to the child's record and to receive copies in a timely fashion.
- Your rights will not be arbitrarily denied.

Early Intervention Officials:

Broome County Health Department
Supervisor of Early Intervention (EIOD)
225 Front Street
Binghamton, NY 13905
(607) 778-2860
(Ask the receptionist to connect you)

Chenango County Early Intervention
Supervisor of Early Intervention (EIOD)
5 Court Street
Norwich, NY 13815
(607) 337-1729
(Ask the receptionist to connect you)

Delaware County Early Intervention
Supervisor of Early Intervention (EIOD)
99 Main Street
Delhi, NY 13753
(607) 832-5200
(Ask the receptionist to connect you)

Tioga County Early Intervention
Supervisor of Early Intervention (EIOD)
1062 State Route 38
Owego, NY 13827
(607) 687-8600
(Ask the receptionist to connect you)

Otsego County Early Intervention
Supervisor of Early Intervention (EIOD)
140 County Hwy. 33W, Suite 3
Cooperstown, NY 13326
(607) 547-6474
(Ask the receptionist to connect you)

Tompkins County Early Intervention
Supervisor of Early Intervention (EIOD)
55 Brown Road
Ithaca, NY 14850
(607) 274-6644
(Ask the receptionist to connect you)

Office for People with Developmental Disabilities:

Broome Developmental Services
249 Glenwood Road
Binghamton, NY 13905
(607) 770-0211

Signature: _____

Date: _____

Name _____ DOB _____ TABS# _____

OPWDD Region 2
Article 16 Clinic/High Risk Births Clinic
305 Main St.
Binghamton, NY 13905

Phone (607) 729-1295
Fax (607) 777-9497

Emergency and Contact Information

Dear individual/parent/guardian/advocate/residential staff:

It is the goal of the Article 16 Clinic and the High Risk Births Clinic to provide the best possible service. The availability of our staff, clinicians, and consultants, however, is limited to our regular business hours: Monday through Friday 8 am to 4 pm. Less urgent matters can be addressed during this time.

For Emergencies

For serious medical concerns, we recommend that one of the following steps be taken:

- Contact your primary physician's office and speak to the Primary Care Physician or one of the associates
- Go to the nearest Walk-In clinic
- Go to the Emergency Room/Psychiatric Crisis Center

* If transporting the individual is a safety concern, you may need to access 911

For Less Urgent Matters

For less urgent matters, contact the main clinic at (607) 729-1295 during our normal business hours, typically, Monday through Friday, 8am-4pm or leave a message on the voicemail system. Messages left on the voicemail system will be returned as soon as possible, usually on the next business day. Printed information can be sent by fax to (607) 777-9497.

If you are receiving PSYCHIATRIC SERVICES and you need to speak to one of the clinic nurses, they can be reached during normal business hours at (607) 729-1295 x113 or x109. If one of the nurses is not able to answer the phone, please leave a message and one of them will return your call.

Article 16/High Risk Births Clinic Treatment Coordinators oversee the services of each individual and manage general questions regarding services. They can be reached during normal business hours or through the voicemail system during non-business hours. Most Clinic Treatment Coordinators can be reached at (607) 729-1295. One Clinic Treatment Coordinator is stationed in Norwich most days and can be reached at 334-3560.

Respectfully,

Clinic Treatment Coordinator or other Clinic Staff

Date

This form will be provided to the residence where the individual lives whether that be at the family home or a certified setting. A copy will be supplied to the individual's Medicaid Service Coordinator.



The Office for People With Developmental Disabilities

Andrew M. Cuomo, Governor
Linda A. Kay, Acting Commissioner

State Operations Office, Region 2
Mark J. Lankes, Director

Article 16 / High Risk Births Clinic
305 Main Street, Binghamton, NY 13905
Phone: (607) 729-1295, Fax: (607) 777-9497

EXPOSURE TO TUBERCULOSIS (TB)

Dear parent or guardian of _____, Date of birth _____, per NYS regulations, I am asking that you inform the High Risk Births Clinic staff if this child has been exposed to any person who has TB.

If the child has not been exposed to TB up until now, but is exposed in the future, please let us know immediately.

If we have no response from you, we will interpret this to mean that the child has not been exposed, or that you are not aware of any exposure.

Thank you for your help,

Sincerely,

[Redacted Signature]

Director, Article 16/HRBC

Copy received by _____ on _____
(parent/guardian) (Date)

Developmental Disabilities State Operations Office 2

Counties Served: Broome, Cayuga, Chenango, Cortland, Delaware, Herkimer, Lewis, Madison, Oneida, Onondaga, Oswego, Otsego, Tioga and Tompkins
(Broome and Central New York DDSOs)

249 Glenwood Road, Binghamton, NY 13905-1695, TEL: 607-770-0211, FAX: 607-770-8037
187 Northern Concourse, N. Syracuse, NY 13212, TEL: 315-473-5050, FAX: 315-473-5053
TTY: 866-933-4889, www.opwdd.ny.gov

Notice of Privacy Practices--Acknowledgment of Receipt

By signing this acknowledgment form I am confirming that:

- I received a copy of OPWDD's Notice of Privacy Practices and the Summary;
- I understand that I can contact my local DDSOO to get more information about my privacy rights in OPWDD.

Individual's name (please print): _____

Individual's signature: _____ Date: _____

If applicable (when the individual is not able to understand the notice):

Name of contact person: _____

Relationship to the Individual: _____

Signature of contact: _____ Date: _____



Notice of Privacy Practices

Effective September 23, 2013

THIS NOTICE DESCRIBES HOW IDENTIFIABLE INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW IT CAREFULLY

If you have any questions about this notice, please contact your local Developmental Disabilities State Operations Office (*See page 4 of this notice for contact number*).

Our Privacy Commitment to You

At OPWDD, we understand that information about you and your services is personal. We are committed to protecting your privacy and sharing information only with those who need to know and are allowed to see the information to assure quality services for you. This notice describes how OPWDD uses and discloses protected health information about you for treatment, payment and health care operations. It also describes your rights to access and control your protected health information and OPWDD's responsibilities to maintain your protected health information. Protected health information (PHI) is information that may identify you and relates to your past, present or future physical or mental health condition, services and payment for such services. Sometimes this information is also referred to as clinical information. In this Notice, protected information will be referred to as "PHI" or "clinical information".

Who will follow this notice?

All people who work for OPWDD in any facility or program directly operated by OPWDD including residences and nonresidential programs such as clinics, day programs, service coordination and supported work, day (nonresidential) services programs, and OPWDD administrative offices will follow this notice. This includes all OPWDD employees and volunteers whom OPWDD allows to assist you.

In addition, contractors, agencies, and other organizations that provide services on behalf of OPWDD who are authorized to access your records and have agreed to protect your information will follow this Notice.

What information is protected?

All information we create or keep that relates to you and your healthcare or treatment, including your name, address, birth date, social security number, medical information, individualized service plan, and other information (such as photographs and other images) is protected.

Your Clinical Information Rights

You have the following rights concerning your clinical information. When we use the word "you" in this notice we also mean your personal representative. Depending on your circumstances and in accordance with state law, this may be your legal guardian, health care agent, or designated legal representative who may include an actively involved family member such as a spouse, domestic partner, parent, adult child, adult sibling, or other family member.

You have the right to:

- See or inspect your clinical information and obtain a copy. Some exceptions apply, such as records regarding incident reports and investigations, and information compiled for use in court or administration proceedings. If we deny your request to see your clinical information, you have the right to request a review of that denial. A Clinical Records Access Review Committee will review the record and decide if you may have access to the record.
- Ask OPWDD to change or amend clinical information that you believe is incorrect or incomplete. We may deny your request in some cases, for example, if the record was not created by OPWDD or if after reviewing your request, we believe the record is accurate and complete.
- Request a list of the disclosures OPWDD has made of your clinical information. The list, however, does not include certain disclosures, such as those made for treatment, payment, and health care operations, or disclosures made to you or made to others with your permission.
- Request that OPWDD communicates with you in a way that will help keep your information confidential.
- Request a restriction on uses or disclosures of your clinical information related to treatment, payment, health care operations, and disclosures to involved family. OPWDD, however, is not required to agree to your request unless you have paid for your services in full with your own money and are requesting restrictions on information pertaining only to those services for payment or health care operations and the disclosure is not required by law.

- Receive a paper copy of this notice. You may ask OPWDD staff to give you another copy or you may obtain one from our website at www.opwdd.ny.gov.
- Be notified following a breach of unsecured PHI. When your clinical information is disclosed to unauthorized persons and can be read by them, we must notify you that this has happened.

Requesting Access to your Clinical Information

To request access to your clinical information or to request any of the rights listed here, you may contact your local Developmental Disabilities Operations Office (*See page 4 of this notice for the contact number for your DDSOO*).

NOTE: OPWDD requires you to make your requests in writing.

OPWDD's Responsibilities For Your Clinical Information

OPWDD is required to:

- Keep and maintain the privacy of your clinical information in accordance with federal and state laws.
- Give you this notice of our legal duties and practices concerning the clinical information we maintain about you.
- Follow the rules in this notice. OPWDD will use or share information about you only with your permission or for one of the reasons explained in this notice.

Tell you if we make changes to our privacy practices in the future. If significant changes are made, OPWDD will give you a new notice and post a new notice on our website at www.opwdd.ny.gov.

How OPWDD Uses and Discloses Clinical Information

OPWDD may use and disclose clinical information without your permission for the purposes described below. For each of the categories of uses and disclosures, we explain what we mean and offer an example. Not every use or disclosure is described, but all of the ways we will use or disclose information will fall within these categories.

Treatment

- OPWDD will use your clinical information to provide you with treatment and services. We may disclose clinical information to doctors, nurses, psychologists, social workers, qualified intellectual disability professionals (QIDPs), direct support professionals, and other OPWDD personnel, volunteers, or interns who work with us to provide you with services.

For example:

- involved staff may discuss your clinical information to develop and carry out your individualized service plan (ISP);

- other OPWDD staff may share your clinical information to coordinate different services you need, such as medical tests, respite care, transportation, etc;
- we may also need to disclose your clinical information to your service coordinator and other providers outside of OPWDD who are responsible for providing you with the services identified in your ISP or to obtain new services for you;
- we may use and disclose clinical information to contact you as a reminder that you have an appointment for treatment or services at one of our programs.

Payment

- OPWDD will use your clinical information so that we can bill and collect payment from you, a third party, an insurance company, Medicare or Medicaid, or other government agencies.

For example:

- we may need to provide the NYS Department of Health (Medicaid) with information about the services you received in our facility or through one of our HCBS waiver programs so they will pay us for the services;
- we may disclose your clinical information to receive prior approval for payment for services you may need;
- we may disclose your clinical information to the federal Social Security Administration or the Department of Health to determine your eligibility for coverage or your ability to pay for services, or to coordinate your benefits and payment for services.

Health Care Operations

- OPWDD will use clinical information for administrative operations. These uses and disclosures are necessary to operate OPWDD programs and residences and to make sure all individuals receive appropriate, quality care.

For example:

- we may use clinical information for quality improvement to review our treatment and services and to evaluate the performance of our staff in caring for you;
- we may disclose information to clinicians and other personnel for on-the-job training;
- we may share your clinical information with other OPWDD staff to: obtain legal services through OPWDD Counsel's Office, conduct fiscal audits, detect fraud and abuse, review incident management, and assure program compliance through our Division of Quality Improvement, Office of Investigations and Internal Affairs, and Employee Relations Office;

- we may share your clinical information with OPWDD staff to resolve complaints or objections to your services;
- we may also disclose clinical information to our business associates who need access to the information to perform administrative or professional services on our behalf. These business associates have the same responsibility as OPWDD to protect the privacy of your information.

Other Uses and Disclosures that Do Not Require your Permission

In addition to treatment, payment, and health care operations, OPWDD will use your clinical information without your permission for the following reasons:

- When required to do so by federal or state law;
- For public health reasons, including prevention and control of disease, injury or disability, reporting births and deaths, reporting abuse or neglect, reporting reactions to medication or problems with products, and to notify people who may have been exposed to a disease or are at risk of spreading the disease;
- To report domestic violence and adult abuse or neglect to government authorities if you agree or if necessary to prevent serious harm;
- For health oversight activities, including audits, investigations, surveys, inspections, and licensure. These activities are necessary for government to monitor the health care system, government programs, and compliance with civil rights laws;
- For judicial and administrative proceedings, including hearings and disputes. If you are involved in a court or administrative proceeding we will disclose clinical information if the judge or presiding officer orders us to share the information;
- For law enforcement purposes; in response to a court order or subpoena; to report a possible crime; to identify a missing person, suspect or witness; to provide identifying data in connection with a criminal investigation; and to the district attorney in furtherance of a criminal investigation of client abuse;
- Upon your death, to coroners or medical examiners for identification purposes or to determine cause of death, and to funeral directors to allow them to carry out their duties;
- To organ procurement organizations to accomplish cadaver, eye, tissue, or organ donations in compliance with state law;
- For research purposes when you have agreed to participate in the research and the Institutional Review Board or Privacy Committee has approved the use of the clinical information for the research purposes;
- To prevent or lessen a serious and imminent threat to

your health and safety or to the health and safety of someone else;

- To authorized federal officials for intelligence and other national security activities authorized by law or to provide protective services to the President and other officials;
- To correctional institutions or law enforcement officials if you are an inmate and the information is necessary to provide you with health care, protect your health and safety or that of others, or for the safety of the correctional institution;
- To governmental agencies that administer public benefits if necessary to coordinate services and benefits you receive or apply for.

Disclosures to Certain Persons If You Agree or Do Not Object

OPWDD may disclose clinical information to the following persons if we tell you we are going to use or disclose it and you agree or do not object:

- To family members and personal representatives who are involved in your care, or in payment for your care, if the information is relevant to their involvement, or to notify them of your condition and location; or
- To disaster relief organizations that need to notify your family about your condition and location should a disaster occur.

Authorization Required For All Other Uses and Disclosures

For all other types of uses and disclosures not described in this Notice, OPWDD will use or disclose clinical information only with a written authorization signed by you that states who may receive the information, what information is to be shared, the purpose of the use or disclosure, and an expiration date for the authorization.

- Written authorizations are always required for use and disclosure of psychotherapy notes (notes of counseling sessions that are kept separate from an individual's clinical record), the sale of PHI, and for marketing purposes.
- Under New York State Law, confidential HIV-related information (information concerning whether or not you have had an HIV-related test, or have HIV infection, HIV-related illness, or AIDS, or which could indicate that a person has been potentially exposed to HIV), cannot be disclosed except to those people you authorize in writing to have it.

- If you have received alcohol or substance abuse treatment from an alcohol/substance abuse program that receives funds from the United States government, federal regulations may further protect your treatment records from disclosure without your written authorization.

NOTE: OPWDD does NOT use your clinical information for marketing or fundraising purposes, nor will we ever sell your clinical information.

Our Responsibility to You

OPWDD is required by state and federal law to maintain the privacy of your health information. We are required to give you this notice of our legal duties and privacy practices with respect to the health information that OPWDD collects and maintains about you. We are required to follow the terms of this notice.

Revocation

You may revoke your authorization to disclose your clinical information at any time. If you revoke your authorization in writing we will no longer use or disclose your clinical information for the reasons stated in your authorization. We cannot, however, take back disclosures we made before you revoked and we must retain clinical information that indicates the services we have provided to you.

Changes to this Notice

We reserve the right to change this notice. We reserve the right to make changes to terms described in this notice and to make the new notice terms effective to all clinical information that OPWDD maintains. We will post the new notice with the effective date on our website at www.opwdd.ny.gov and in our facilities. In addition, we will offer you a copy of the revised notice at your next scheduled service planning meeting.

Complaints

If you believe your privacy rights have been violated:

- You may file a complaint with the Director of your local Developmental Disabilities State Operations Office (DDSOO).
- You may contact the Secretary of the Department of Health and Human Services. [200 Independence Ave. S. W. Washington D. C. 20210, phone 1-877-696-6775]
- You may file a grievance with the Office for Civil Rights Region II office at Jacob Javits Federal Building, 26 Federal Plaza – Suite 3312, New York, NY 10278. Voice phone (800) 368-1019; FAX (212) 264- 3039; TDD (800) 537-7697, or by email: OCRComplaint@hhs.gov.

All complaints must be submitted in writing. You will not be penalized for filing a complaint.

Developmental Disabilities State Operations Office Contact Numbers

Developmental Disabilities State Operations Office 1
Finger Lakes Region
585-461-8500, FAX: 585-461-8764,

Western New York Region
716-517-2000, 800-487-6310, FAX: 716-674-7488

Developmental Disabilities State Operations Office 2
Broome Region
607-770-0211, FAX: 607-770-8037

Central New York Region
315-473-5050, FAX: 315-473-5053

Developmental Disabilities State Operations Office 3
Capital District
518-370-7331, FAX: 518-370-7401

Sunmount Region
518-359-3311, FAX: 518-359-4491

Developmental Disabilities State Operations Office 4
Hudson Valley Region
845-947-6100, FAX: 845-947-6004

Taconic Region
845-877-6821, FAX: 845-877-9177

Developmental Disabilities State Operations Office 5
Brooklyn
718-642-6000,
718-642-6053/6054 (evenings - answering machine)
FAX: 718-642-6282

Manhattan
212-229-3000, FAX: 212-924-0580

Bronx
718-430-0700, FAX: 718-430-0842
718-983-5200, FAX: 718-983-9768

Staten Island
718-642-6000, FAX: 718-642-6282

Developmental Disabilities State Operations Office 6
Bernard M. Fineson
718-217-4242, FAX: 718-217-4724

Long Island
631-493-1700, FAX: 631-493-1865



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Consent to Release

I, _____, parent/guardian of _____
Consent to give The High Risk Births Clinic permission to release a
copy of the completed evaluation report on my child to the
following:

Parents/Guardians:

EI Service Coordinator:

Primary Care Physician:

Other:

Other:

Signature: _____ Date: _____

Developmental Disabilities State Operations Office 2

Counties Served: Broome, Cayuga, Chenango, Cortland, Delaware, Herkimer, Lewis, Madison, Oneida, Onondaga, Oswego, Otsego, Tioga and Tompkins
(Broome and Central New York DDSOs)

249 Glenwood Road, Binghamton, NY 13905-1695, TEL: 607-770-0211, FAX: 607-770-8037

We help people with developmental disabilities live richer lives



FAMILY NEEDS ASSESSMENT FORM

Date: _____

Dear _____

As you are aware your child has been referred for a developmental evaluation by Early Intervention. As an Early Intervention provider, we must offer to provide a family assessment as part of the evaluation process. A family assessment is designed to help the family determine their resources, priorities and concerns in relation to the child's development. It is your right to choose whether you would like to participate in a family assessment. If you should choose not to participate in the family assessment process, it shall in no way impact the determination of eligibility to receive services or the type of services which may be provided to the child and their family. Please place an (X) in a box below to indicate your choice:

No, I do not wish to take part in a family assessment

YES, I would like to take part in a family assessment

Once you have selected your choice, please sign and return in the self addressed stamped envelope.

Signature

Date

Thank You.
Lisa Collins, LMSWI

Developmental Disabilities State Operations Office 2

Counties Served: Broome, Cayuga, Chenango, Cortland, Delaware, Herkimer, Lewis, Madison, Oneida, Onondaga, Oswego, Otsego, Tioga and Tompkins
(Broome and Central New York DDSOs)

We help people with developmental disabilities live richer lives



BROOME DEVELOPMENTAL SERVICES
High Risk Births Clinic
305 Main Street
Binghamton, NY 13905
(607) 729-1295

Record Access Log

Re: _____ DOB: _____
(child's name)

<u>Person accessing record:</u>	<u>Date:</u>	<u>Time:</u>	<u>Purpose:</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Developmental Disabilities State Operations Office 2

Counties Served: Broome, Cayuga, Chenango, Cortland, Delaware, Herkimer, Lewis, Madison, Oneida, Onondaga, Oswego, Otsego, Tioga and Tompkins
(Broome and Central New York DDSOs)

We help people with developmental disabilities live richer lives

**BROOME DEVELOPMENTAL SERVICES
HIGH RISK BIRTHS CLINIC
EARLY INTERVENTION REPORT**

INITIAL EVALUATION

Name:	Date of Evaluation:
Date of Birth:	TABS ID #:
Chronological Age:	Gestational Age:

BACKGROUND INFORMATION

Referral Source:
Service Coordinator:
Referral Reason:

(Short narrative describing the child and family)

Transportation needs:

A Family Assessment was offered but the family did not want to participate at this time.

Or

The family participated in a formal Family Assessment to identify strengths/needs.

MEDICAL HISTORY

Information reviewed:
Information to be reviewed when received:

- Early Intervention Intake obtained by Initial Service Coordinator
- Medical reports from hospital where labor/delivery occurred
- Medical reports from child's primary physician

Briefly describe medical issues. Include any family history of developmental delays.

Documentation of Blood Lead Level (BLL) was/was not present in this child's health assessment.

EVALUATION PROCEDURE

_____ was seen at the _____ with _____ present. _____ participated in the evaluation by asking and answering questions relative to _____ development.

The following clinicians provided evaluations:

Mary Snyder, Sr. P.T.....Reflex/Muscle Tone/Gross Motor Evaluation
Sherry Miller, Sr. OTR.....Fine Motor/Adaptive/Sensory Motor Evaluation
Evaluation
Camille Lepre, SLP II.....Oral Motor/Speech-Language Evaluation
Beth Kelly, Dev Spec III..... Motor/Cognitive/Social-Emotional/Adaptive
Evaluation
Lisa Collins, LMSWI...Family Needs Assessment

EVALUATION RESULTS

Primary Language Spoken in the Home: English

Parent Perception of Evaluation: _____ reported that the evaluation accurately reflected _____ strengths and weaknesses.

DEVELOPMENTAL ASSESSMENT

PHYSICAL DEVELOPMENT

Primary Physician:
Allergies:
Current Medications:
Date of last physical exam:
Medical concerns identified at last exam:
Date of next scheduled exam:

SENSORY FUNCTIONING

Vision:

Hearing:

Sensory Processing:

MOTOR DEVELOPMENT

Reflex Summary:

Muscle Tone, Strength, and Range of Motion:

Gross Motor Skills:

Fine Motor Skills:

Name:
Date:

Oral Motor Skills:

COMMUNICATION DEVELOPMENT

COGNITIVE DEVELOPMENT

SOCIAL-EMOTIONAL DEVELOPMENT

ADAPTIVE DEVELOPMENT

SUMMARY OF DEVELOPMENT

PHYSICAL

CURRENT STATUS

Vision
Hearing

Gross Motor
Fine Motor
Total Motor Score

COMMUNICATION

Receptive
Expressive
Total Communication Score

COGNITIVE

SOCIAL-EMOTIONAL

ADAPTIVE

EARLY INTERVENTION ELIGIBILITY STATEMENT

DIAGNOSTIC IMPRESSION

OPWDD ELIGIBILITY

It has been discussed with the EI service coordinator that this child is potentially eligible for OPWDD services. It is recommended the EI service coordinator and family

Name:
Date:

3

EI ID#:

discuss whether it would be beneficial to refer the child to OPWDD for eligibility determination and possible services that may help the child meet his/her highest potential.

TEAM RECOMMENDATIONS

RE-EVALUATION RECOMMENDATION AND DATE:

At this time, evaluation results are within the average range and additional testing is not indicated. Due to the ever changing rate of child growth no definitive statement can be made regarding future developmental needs.

Please do not hesitate to contact this clinic should you have future concerns about your child's development.

If you have additional concerns about your child, you can contact your Early Intervention Service Coordinator.

This report was respectfully submitted by the following clinicians of the High Risk Births Clinic:

██████████ Sr.PT
Senior Physical Therapist

██████████ OTR/L
Senior Occupational Therapist

██████████ M.S., CCC-SLP II
Speech-Language Pathologist II

██████████ M.S., M.S. Ed.
Developmental Specialist III.

██████████ LMSWI
Licensed Master Social Worker

High Risk Births Clinic-Broome Developmental Services
305 Main Street
Binghamton, NY 13905

(607) 729 - 1295
Fax (607) 777 - 9497

Multidisciplinary Evaluation Summary

Child's Name: _____ DOB: _____ Chron Age: _____ Gest Age: _____
DOE: _____ Parent Name & Address: _____ Referral Reason: _____
Primary Physician: _____ Date of Last Exam: _____ EISC: _____
Hearing Concerns: YES / NO Vision Concerns: YES / NO Transportation Concerns: YES / NO
Was the Child's response today typical: YES / NO Family Assessment Choice: YES / NO
Evaluation Findings Discussed with Parent: YES / NO ICD 9 Code: _____
Eligibility Findings: Not Eligible / Eligible Based on: _____

<u>Gross Motor Strengths/Weaknesses:</u>	Total Motor Standard Score: _____ Standard Deviation: _____
Choose One: <input type="checkbox"/> AIMS <input type="checkbox"/> Bayley, 3 rd Ed. <input type="checkbox"/> DAY-C <input type="checkbox"/> Peabody, 2 nd Ed. Standard Score: _____ Standard Deviation: _____ Is this an Area of Need: YES / NO	
<u>Fine Motor Strengths/Weaknesses:</u>	Is this an Area of Need: Yes / NO
Choose One: <input type="checkbox"/> Bayley, 3 rd Ed. <input type="checkbox"/> DAY-C <input type="checkbox"/> Peabody, 2 nd Ed. Standard Score: _____ Standard Deviation: _____ Is this an Area of Need: YES / NO	
<u>Social-Emotional Strengths/Weaknesses:</u>	
Choose One: <input type="checkbox"/> Bayley, 3 rd Ed. <input type="checkbox"/> DAY-C Standard Score: _____ Standard Deviation: _____ Is this an Area of Need: YES / NO	
<u>Communication Strengths/Weaknesses:</u>	
Choose One: <input type="checkbox"/> DAY-C <input type="checkbox"/> PLS, 4 th Ed. <input type="checkbox"/> REEL, 3 rd Ed. Standard Score: _____ Standard Deviation: _____ Is this an Area of Need: YES / NO	
<u>Cognitive Strengths/Weaknesses:</u>	
Choose One: <input type="checkbox"/> Bayley, 3 rd Ed. <input type="checkbox"/> DAY-C Standard Score: _____ Standard Deviation: _____ Is this an Area of Need: YES / NO	
<u>Adaptive Strengths/Weaknesses:</u>	
Choose One: <input type="checkbox"/> Bayley, 3 rd Ed. <input type="checkbox"/> DAY-C <input type="checkbox"/> Dev Pre-Feeding Checklist Standard Score: _____ Standard Deviation: _____ Is this an Area of Need: YES / NO	

Evaluator(s) Signature: _____

Evaluator(s) Signature: _____

EARLY INTERVENTION MULTI-DISCIPLINARY EVALUATION SUMMARY FORM

Child's Name: _____

DOB: _____

Date of Evaluation Establishing Eligibility: ___/___/___

Date of Evaluation for Ongoing Eligibility: ___/___/___

NOT ELIGIBLE

Write V79.3 – Not eligible. Attach evaluation report. Attach core/supplemental evaluation summary sheets.

**ELIGIBLE – BASED ON
DIAGNOSED CONDITION**

Sufficient to determine eligibility. Submit the following:

1. Indicate Diagnostic Condition in Part A. Attach documentation of diagnosis.
2. Attach core evaluation – Data Entry Form, Supplemental data entry form(s) and narrative summary of evaluation
3. Attach all evaluation reports

ELIGIBLE – BASED ON DELAY

Submit the following to assist in developing a service plan.

1. This page
2. Core Evaluation-Data Entry Form, Supplemental Evaluation data entry form(s) and narrative summary.
3. Attach all evaluation reports.
4. Indicate ICD-9 Code in Part B

A. Diagnosed Physical and Mental Conditions with a High Probability of Developmental Delay. Complete this section only if child is eligible based on diagnosed condition. Attach documentation of diagnosis by physician or clinician.

- | | |
|--|---|
| <ul style="list-style-type: none"> <input type="checkbox"/> 270.2 – Albinism <input type="checkbox"/> 759.89 – Anglemán's <input type="checkbox"/> 743.45 – Aniridia <input type="checkbox"/> 728.3 – Arthrogyposis <input type="checkbox"/> 314.00 – Attention Deficit Disorder w/o Hyperactivity <input type="checkbox"/> 314.01 – Attention Deficit Disorder w/ Hyperactivity <input type="checkbox"/> 369.00 – Blindness, both eyes <input type="checkbox"/> 369.10 – Blindness one eye, low vision other eye <input type="checkbox"/> 749.00 – Cleft Palate <input type="checkbox"/> 759.7 – CHARGE Association <input type="checkbox"/> 389.00 – Conductive Hearing Loss – NOS <input type="checkbox"/> 742.3 – Congenital Hydrocephalus <input type="checkbox"/> 359.0 – Congenital Muscular Dystrophy <input type="checkbox"/> 348.8 – Cystic Periventricular Leukomalacia (CVPL) <input type="checkbox"/> 315.31 – Dyspraxia Syndrome <input type="checkbox"/> 758.0 – Down (Trisomy 22 or 22, G) <input type="checkbox"/> 758.2 – Edwards' (Trisomy 18 D 1) <input type="checkbox"/> 313.9 – Emotional Disturb. of Childhood (Unspecified) <input type="checkbox"/> 742.0 – Encephalocele <input type="checkbox"/> 760.71 – Fetal Alcohol <input type="checkbox"/> 759.83 – Fragile X <input type="checkbox"/> 299.00 – Infantile Autism active state <input type="checkbox"/> 343.9 – Infantile Cerebral Palsy – NOS <input type="checkbox"/> 345.60 – Infantile Spasms w/o intractable epilepsy <input type="checkbox"/> 345.61 – Infantile Spasms with intractable epilepsy <input type="checkbox"/> 772.1 – Intraventricular Hemorrhage (grade IV) <input type="checkbox"/> 774.7 – Kernicterus | <ul style="list-style-type: none"> <input type="checkbox"/> 765.0 – Less than 500 grams – Low Birth Weight <input type="checkbox"/> 765.02 – 500 – 749 grams – Low Birth Weight <input type="checkbox"/> 765.03 – 750 – 999 grams – Low Birth Weight <input type="checkbox"/> 755.58 – Lobster claw (hand) <input type="checkbox"/> 369.20 – Low vision both eyes (moderate to severe) <input type="checkbox"/> 742.1 – Microcephalus <input type="checkbox"/> 389.2 – Mixed conductive and sensorineural hearing loss <input type="checkbox"/> 724.4 – Multiple anomalies of brain – NOS <input type="checkbox"/> 377.23 – Optic nerve coloboma (bilateral), acquired <input type="checkbox"/> 743.57 – Optic nerve coloboma (bilateral), congenital <input type="checkbox"/> 359.8 – Other Myopathies <input type="checkbox"/> 758.1 – Patau's (Trisomy 13 D 1) <input type="checkbox"/> 299.80 – Pervasive Developmental Disorder (PDD) <input type="checkbox"/> 75.4 – Phocomelia (absence of limb) <input type="checkbox"/> 759.81 – Prader-Willi <input type="checkbox"/> 309.81 – Prolonged Post Traumatic Stress Disorder <input type="checkbox"/> 742.2 – Reduction deformities of brain (Holoprosencephaly/Lissencephaly) <input type="checkbox"/> 362.21 – Retinopathy of prematurity (grades 4 & 5) <input type="checkbox"/> 389.10 – Sensorineural Hearing Loss (NOS) <input type="checkbox"/> 741.00 – Spina Bifida with hydrocephalus <input type="checkbox"/> 741.90 – Spina Bifida w/o hydrocephalus <input type="checkbox"/> 952.9 – Spinal cord injury, NOS <input type="checkbox"/> 744.00 – Unspecified anomalies of ear w/ hearing impairment <input type="checkbox"/> 379.53 – Visual deprivation nystagmus <input type="checkbox"/> 355.0 – Werdnig-Hoffman Syndrome (Infantile Spinal Muscular Dystrophy) |
|--|---|

B. Indicate Diagnostic Condition and ICD-9 Code(s) below if eligible due to delay or if different from above.

1. _____

2. _____

**EARLY INTERVENTION PROGRAM
MULTI-DISCIPLINARY EVALUATION SUMMARY FORM**

INSTRUCTIONS: This form must be accompanied by the Multi-Disciplinary Evaluation Summary Form, Supplemental Evaluation Data Entry Form (when applicable) and Narrative Summary. Please print or type.

Name of Child: _____
Last
First
Middle

DOB: _____ Date of Evaluation: _____

EI Evaluator:	
Name: _____	Phone #: _____
Provider ID: _____	Fax #: _____
Contact Person: _____	

<u>Core Evaluation – Individuals Involved:</u>	<input type="checkbox"/> Check is Bilingual Evaluation Performed. Language: _____ Summary of evaluation must be translated.
Name: _____	Dates of Core:
Specialty: _____	From: ___/___/___ To: ___/___/___
Instrument(s): _____	

Name: _____	Name: _____
Specialty: _____	Specialty: _____
Instrument(s): _____	Instrument(s): _____

<input type="checkbox"/> Family Assessment Offered & Refused	<input type="checkbox"/> Family Assessment Completed & Attached
--	---

Disciplines involved in core evaluation: <input type="checkbox"/> Audiologist <input type="checkbox"/> Other Physician <input type="checkbox"/> Nurse <input type="checkbox"/> Physician Assistant <input type="checkbox"/> Nurse Practitioner <input type="checkbox"/> Psychologist <input type="checkbox"/> Nutritionist <input type="checkbox"/> Social Worker <input type="checkbox"/> Occupational Therapist <input type="checkbox"/> Special Educator <input type="checkbox"/> Pediatrician <input type="checkbox"/> Speech/Language Pathologist <input type="checkbox"/> Physical Therapist	(1) Developmental Status Codes: A – No delay (development w/in acceptable ranges) B – 2.0+ SD below the mean (sufficient alone for eligibility) C – 1.5+ SD below the mean in 2 areas (similar delay in another functional area needed to establish eligibility) L – 1.0 + SD in 1 area (for continuing eligibility) D – 12 month delay (sufficient alone for eligibility) F – 33% or more delay (sufficient alone for eligibility) G – 25% or more delay in 2 areas (similar delay in another functional area needed to establish eligibility) K – Qualitative Criteria H – Suspect I – Slight Delay
Method: P – Informed Clinical Opinion T – Standardized Test	

EVALUATION SUMMARY			Diagnosed condition(s)	ICD-9 Code
Functional Area	Developmental Status	Method		
Adaptive				
Cognitive				
Communication				
Social/Emotional				
Physical				

Entered by/date: _____ Peer review by/date: _____



NYS Office For People With Developmental Disabilities

Andrew M. Cuomo, Governor
Laurie A. Kelley, Acting Commissioner

State Operations Office, Region 2
Mark J. Lankes, Director

High Risk Births Clinic/ Broome Developmental Services

NPI #: 1316088941
305 Main Street
Binghamton, NY 13905
(607) 729-1295
(607) 777-9497 (fax)

Early Intervention Verification of Evaluation

Child's Name: _____ DOB: _____ M ___ F ___

ICD-9: R/O 315.9 Developmental Delay, Unspecified

Address where services are provided: _____

Date of Service	Start Time	AM PM	End Time	AM PM	Min per Session	CPT Code (circle one)
						CL0400 ≥2hrs CL0401 < 2 hrs

Parent/Guardian: Please note that by signing this form you are giving consent for the High Risk Births Clinic (who is contracting with the County Health Department) to complete the Multidisciplinary Evaluation (MDE) for your child and acknowledging to the date/time of the evaluation.

Evaluation Attendance/Consent for Evaluate Form

Print Name:	Signature:	Title/Relationship

All others in Attendance:

Print Name:	Signature:	Title/Relationship

Form Revised: 12/2013 EI Authorization #: _____

Developmental Disabilities State Operations Office 2

Counties Served: Broome, Cayuga, Chenango, Cortland, Delaware, Herkimer, Lewis, Madison, Oneida, Onondaga, Oswego, Otsego, Tioga and Tompkins
(Broome and Central New York DDSOs)



BROOME DEVELOPMENTAL SERVICES
High Risk Births Clinic
305 Main Street
Binghamton, NY 13905
(607) 729-1295

Consent to Treat

I, _____, parent/legal guardian for
_____, consent to allow
_____, to provide therapy in accordance
with my child's Individualized Family Service Plan (IFSP). Treatment
dates are from _____ to _____.

Signature of parent/guardian: _____

Date of consent: _____

Developmental Disabilities State Operations Office 2

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We help people with developmental disabilities live richer lives

HIGH RISK BIRTHS CLINIC
 RELEASES SENT/DOCUMENTS RECEIVED
 TRACKING TOOL

CHILD'S NAME: _____

	INFORMATION REQUESTED FROM:	DATE SENT:	DATE RECEIVED:
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

SCRIPT REQUESTED:	SCRIPT RECEIVED:

PURPOSE		<input type="checkbox"/> Screening	<input type="checkbox"/> Registration	<input type="checkbox"/> Readmission
		<input type="checkbox"/> Transfer	<input type="checkbox"/> Demographic Data Change	<input type="checkbox"/> Diagnostic Update
CE-1 Registration Screen				
1. Name (Last, First, M.I.)(Please Print)		2. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		3. Date of Birth / /
4. Registration /Screen date / /		5. County of Residence		6. County of Interest
7. Current Address		Telephone # () -		
8. Residence Type	9. Social Security # - -	10. CIN Number		12. Medicare #
13. Ethnicity Race	14. Hispanic Origin <input type="checkbox"/> Yes <input type="checkbox"/> No	15. U.S. Citizen <input type="checkbox"/> Yes <input type="checkbox"/> No	16. Country of Birth	17. Referral Source
18. Marital Status	19. Religion Code	20 Religious Denomination	21 Primary Disability	22. Secondary Disability
23. Special Pop. Indicator	24. Spoken Language	25. Non-verbal Lang. Code	26. Education Code	27. School District
28. Registration Comments:				
29. Understood Language:		30. Wheelchair: <input type="checkbox"/> Yes <input type="checkbox"/> No		31. CE2 :Add to Program: If accepted for Services:
				DATE: / /
				Program Name
				Program Code
32. CE 7 – 9:Diagnostic Information:				
Diagnosis date: / /		Clinician Signature:		
Primary Diagnosis:			Code:	
Etiology:			Code:	
Other Significant Diagnosis:			Code:	
Date of Test: / /		Test Type:		Test Results:
Source of Diagnostic Information:				
33. CE10: Legal Screen:				
Legal Status:			Legal Status Code:	
Effective Date: / /		Expiration Date: / /		
34. CE11: Correspondence Screen:				
Correspondent Type: _____		Status: _____		Relationship: _____
Primary Name:		Secondary/Attention Name:		
Address:		City:		State: Zip:
Work Phone: () -		Home Phone: () -		Mail Status _____
35. CE16: Facility Consecutive # 0233				
OMR/DD 725 (3/95) TABS REGISTRATION/ SCREENING FORM (Send Completed form to TABS Data entry person for data entry processing)		Completed By: _____		
		Title:		Date:
		Data Entered By:		Date:

CENTRAL NEW YORK DSO BOWEL ELIMINATION RECORD

Name	
Month:	Year:

Legend			
Size		Consistency	
Extra Large	X	Hard	H
Large	Lg	Soft	S
Medium	M	Watery	W
Small	S	Loose	L

Complete for all individuals as indicated by RN.
If individual is independent in toileting, RN will direct BM recording of signs of constipation per Bowel Elimination Protocol.

Date of Last BM from Previous Month:

	BM #1					BM #2					BM #3				
	Time a.m./p.m.	Size	Consistency	Color	Initials	Time a.m./p.m.	Size	Consistency	Color	Initials	Time a.m./p.m.	Size	Consistency	Color	Initials
1															
2															
3															
4															
5															
6															
7															
8															
9															
10															
11															
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27															
28															
29															
30															
31															

Central New York Developmental Disabilities State Operations Office

Article 16 Clinic

RECEIPT OF BILL OF RIGHTS

I have received a copy of the CNY DDSOO's Article 16 Clinic Bill of Rights.

Individual's Name: _____ TABS# _____

Signature: _____

If the individual is unable to sign, please provide a signature and the relationship of the person that received and reviewed the Bill of Rights with the above individual.

Signature: _____

Relationship: _____

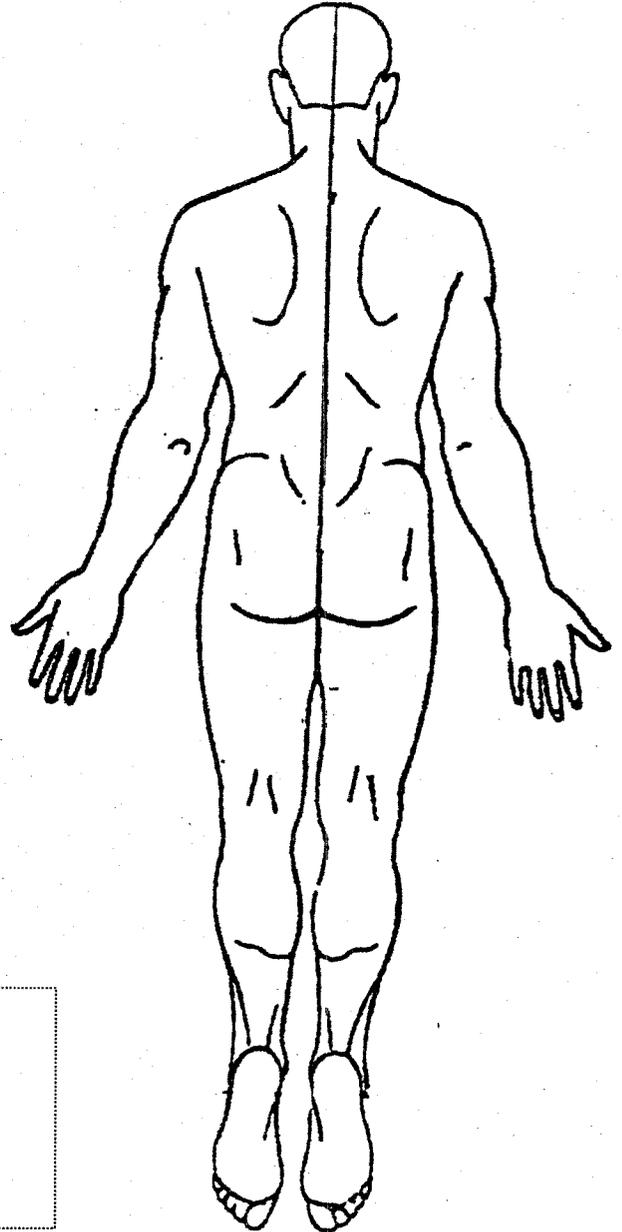
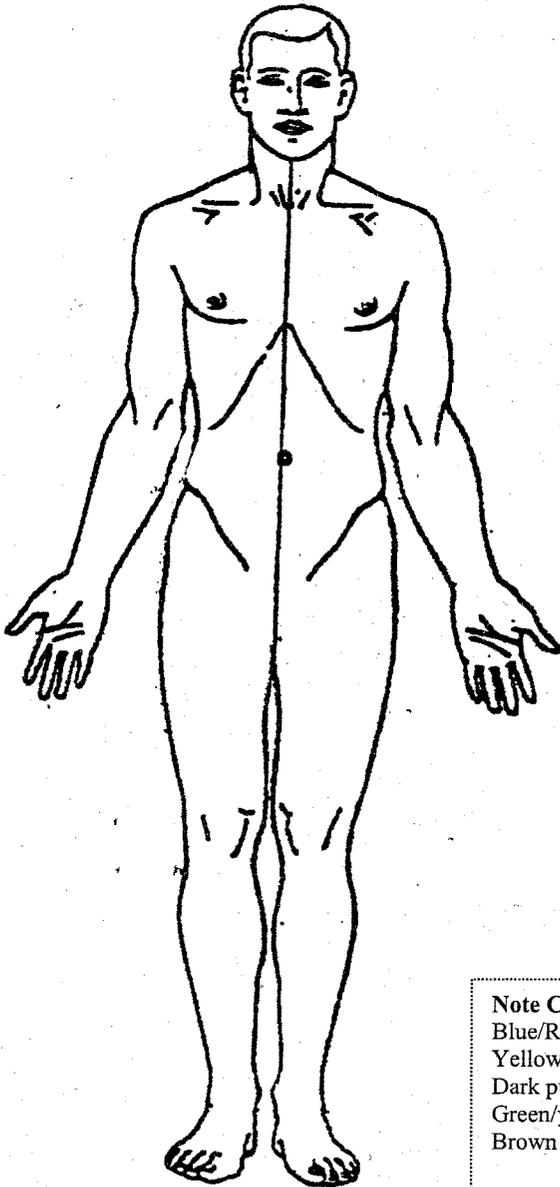
Consumer Name:	Date:	Time:
-----------------------	--------------	--------------

am/pm

Reason for Body Check (check all that apply):

Allegation of Abuse
 Injury
 Other: Reason _____

Directions: Body charts should be completed anytime a reportable injury occurs, or when an Allegation of Abuse is filed that may involve either an injury or other sign of mistreatment. If a body check is being conducted as a result of an Allegation of Abuse, staff uninvolved in the matter should complete the body check whenever possible. Notations/Descriptions can be made in the space provided below. Note location, size, and color of mark(s). Notations can be made on or beside the figure. Additional comments can be written on the reverse side of the form if necessary.



Note Color of Bruise
 Blue/Red
 Yellow edge
 Dark purple
 Green/yellow
 Brown

Signature and Title of all staff completing form:

Printed Name:	Signature:	Title:
Printed Name:	Signature:	Title:

Audiology Reschedule

_____ was scheduled for an audiology appointment on
_____ at _____. The appointment was
(changed, cancelled/rescheduled, No Call No Show).

The appointment was rescheduled for

_____ at _____.

Date _____ Signature _____

Article 16 Service Request: Enroll/Add/Delete

TO: OPWDD Region 2 Article 16 Clinic – CNY DDSOO () at Fair Lakes () at Rome		
FROM: MSC/QIDP:	Phone:	Agency:
RE: Individual Name:		Residence:

SECTION 1 A: ENROLL IN CLINIC OR ADD A SERVICE: **INITIAL SERVICE(S)** **ADD SERVICE(S)**

As the Medicaid Service Coordinator for this individual, I have determined in conjunction with other members of the individual’s treatment team and **primary medical practitioner** that an unmet clinical need exists or may exist for this individual.

Service	Presenting Problem	Clinic Site/Location
1.		
2.		
3.		

SECTION 1B: DELETE A SERVICE OR DISCHARGE FROM CLINIC **DELETE SERVICE(S)** **DISCHARGE FROM CLINIC**

As the Medicaid Service Coordinator for this individual, I have determined in conjunction with other members of the individual’s treatment team, individual/collateral, as well as the primary medical practitioner that the following Article 16 Clinic services be discontinued/deleted.

Service	Reason for Deletion/Discharge	Clinic Site/Location
1.		
2.		
3.		

SECTION 2: MSC or Referring Party STATEMENT

- A) I understand that the Article 16 Clinic is *the provider of last resort* and I have made a good faith effort to identify providers in the community without success.
- B) I understand that in most circumstances, Article 16 Clinics are not able to provide duplicate services and that the service(s) requested is(are) not already provided to this individual elsewhere. If it is currently provided elsewhere, it will be indicated on the BRM-CL 627 form.
- C) I understand that enrollment in Article 16 programs requires that all elements of participation be adhered to in order for an appropriate authorization of these Medicaid Services. Understanding this:
 - I am providing all required forms and documentation as is required by Article 16 procedures to meet Part 679 regulations.
 - When missing information/documentation is discovered or regulatory or programmatic requirements change, upon notification, I will provide all required forms, documentation, or other information within requested times frames.
 - I understand that lack of compliance with these elements of participation may result in termination from Article 16 services.

MSC or Referring Party SIGNATURE _____ Date _____

SECTION 3: CHECKLIST for DOCUMENTATION REQUIRED* from MSC or REFERRING PARTY

*Initial/New Service	Add a Service	Delete Service
<input type="checkbox"/> Article 16 Application		
<input type="checkbox"/> Primary Care Practitioner Referral	<input type="checkbox"/> Primary Care Practitioner Referral	<input type="checkbox"/> Termination note or ISP Addendum **
<input type="checkbox"/> Copy of DDP-2 (within last 2 yrs and reflecting current status)	<input type="checkbox"/> Pertinent assessments	
<input type="checkbox"/> Copy of DDP-4 (reflecting the identified service need)	<input type="checkbox"/> Allergies List (updated)	
<input type="checkbox"/> Copy of ISP or PISP and/or ISP addendum reflecting the presenting problem/need. Include IPOP/Behavior Plan. If individual does not have an ISP, substitute with a CFA, IFSP, or IEP.	<input type="checkbox"/> Copy of ISP and/or ISP addendum reflecting the presenting problem/need	
<input type="checkbox"/> Pertinent assessments		
<input type="checkbox"/> Most Recent Annual Physical Exam		
<input type="checkbox"/> Allergies List		
<input type="checkbox"/> Proof of Negative PPD test or Statement with Reason for Lack of Documentation		
<input type="checkbox"/> Proof of Eligibility: At least ONE of the following (listed in order of preference): completed IPP4, Letter of Eligibility, NOD, DDP2, TABS CR4 (Master Individual Hx)		
<input type="checkbox"/> Bill of Rights Receipt		
<input type="checkbox"/> Privacy Practice Acknowledgement		
<input type="checkbox"/> Insurance Cards (copy)		

*Additional information may be required once the original application packet is reviewed

** Clinic **must** have a written statement from MSC agency indicating **why service is no longer needed**

Appointments

Name:	IMMUNIZATIONS	Frequency	Date of Last	Date Due - Provider	Comments/Notes
	Hep B Series	Per Protocol			
Site:	Tetanus/Diph	10 years			
	2 step PPD	Within 1 year	1	Date of step 2:	
Date Of Birth:	Influenza	Annual			
	Pneumonia				
	Pertussis				

Allergies

APPOINTMENT	Frequency	Date of last	Next Appt	Appt made	Doctor/provider	Comments/Notes
Primary Physician	Various					
Physical Exam	Annual					
Dentist	6 Months					
Audiology	Per MD order					
Eye (vision)	Q2Y / PRN					
Gynecology	Annual					
Neurology	PRN					
Psychiatry	6-12 Months					
Cardio	PRN					
GI	PRN					
Podiatry	Q3M / PRN					
Other						

RADIOLOGY

Colonoscopy	Age 50/PRN					
Bone Density (Osteo Eval)	Per MD order					
Chest X-ray	Per MD order					
EKG						
Mammogram (Female)	Annual/PRN					
Pap Smear (Female)						
Breasts Exam (Female)	Annual/PRN					
Other						

LABS

CBC	Per MD order					
Chemistry	Per MD order					
Lipids	Per MD order					
LFT	Per Protocol					
HgA1c	3 months					
TSH	Per Protocol					
Other						

Affirmation of Medication Administration by Shift Assigned ("Floated") Staff.

This form is to be completed by the AMAP who is shift assigned ("floated") to administer medication at a location other than their permanently assigned work locations when there is no permanently assigned AMAP/LPN available to administer medications at that location.

The AMAP who is shift assigned ("floated") to administer medication must complete these steps before administering medication:

- 1 Review the MARs, and the consumer specific information, (with the off-going AMAP or LPN if available)
- 2 If you still have questions, or are uncomfortable with administering a particular medication, call the RN/RN-On-Call to discuss your concerns prior to medication administration
- 3 Sign the form below, indicating that you have reviewed the medications, had any question answered, and are comfortable and confident in the administration of medication

Date	Time	I have reviewed the MARs, and the consumer specific medication information, and contacted the RN/RN-On-Call, (if needed, to answer any questions regarding medication administration), and am comfortable and confident in the administration of medication. Signature	I have contacted the RN/RN-On-Call if I had any questions regarding medication administration or if I was uncomfortable with administering a particular medication. Enter name of RN or "No questions"	I have reviewed the MARs and consumer specific medication information with the shift assigned staff or write "No AMAP/LPN available" if AMAP reviewed the information alone. Off-going AMAP/LPN Signature

Note: This form is to be kept with the Medication Administration Records

Name _____ DOB _____ TABS# _____

Allergies

None Known

Yes

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.
- 7.
- 8.

ABNORMAL INVOLUNTARY MOVEMENT SCALE (AIMS)

Patient's Name (Please print) _____ Patient's ID information _____

Examiner's Name _____

CURRENT MEDICATIONS AND TOTAL MG/DAY

Medication #1 _____ Total mg/Day _____ Medication #2 _____ Total mg/Day _____

INSTRUCTIONS: COMPLETE THE EXAMINATION PROCEDURE BEFORE ENTERING THESE RATINGS.

Facial and Oral Movements

1. Muscles of Facial Expression eg, movements of forehead, eyebrows, periorbital area, cheeks; include frowning, blinking, smiling, grimacing
2. Lips and Perioral Area eg, puckering, pouting, smacking
3. Jaw eg, biting, clenching, chewing, mouth opening, lateral movement
4. Tongue
Rate only increases in movement both in and out of mouth, NOT inability to sustain movement

None, normal *Minimal (may be extreme normal)*
Mild *Moderate* *Severe*

<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄

Extremity Movements

5. Upper (arms, wrists, hands, fingers)
Include choreic movements (ie, rapid, objectively purposeless, irregular, spontaneous); athetoid movements (ie, slow, irregular, complex, serpentine). DO NOT include tremor (ie, repetitive, regular, rhythmic).
6. Lower (legs, knees, ankles, toes)
eg, lateral knee movement, foot tapping, heel dropping, foot squirming, inversion and eversion of foot

<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄

Trunk Movements

7. Neck, shoulders, hips
eg, rocking, twisting, squirming, pelvic gyrations

<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
---------------------------------------	---------------------------------------	---------------------------------------	---------------------------------------	---------------------------------------

SCORING:

- Score the highest amplitude or frequency in a movement on the 0-4 scale, not the average;
- Score Activated Movements the same way; do not lower those numbers as was proposed at one time;
- A POSITIVE AIMS EXAMINATION IS A SCORE OF 2 IN TWO OR MORE MOVEMENTS or a SCORE OF 3 OR 4 IN A SINGLE MOVEMENT
- Do not sum the scores: e.g. a patient who has scores 1 in four movements DOES NOT have a positive AIMS score of 4.

Overall Severity

8. Severity of abnormal movements
9. Incapacitation due to abnormal movements

<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄

10. Patient's awareness of abnormal movements (rate only patient's report)

	<i>No awareness</i>	<i>Aware, no distress</i>	<i>Aware, mild distress</i>	<i>Aware, moderate distress</i>	<i>Aware, severe distress</i>
<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	

Dental Status

11. Current problems with teeth and/or dentures?
12. Does patient usually wear dentures?

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

Comments: _____

Examiner's Signature _____ Next Exam Date _____