careLOFT day program

INDIVIDUAL NEEDS

Name _____ **Name of Assessor** _____ **Date** _____

INSTRUCTIONS: Complete this summary by providing the most current and accurate information available.
If this form does not highlight areas of need, which are significant, please attach a page addressing these areas.

HEALTH - MEDICAL				
Allergies ☐ Yes ☐ No	**To Food:**	**To Medication:**	**To Bee Stings:**	**Other:**
Recommended Response to Allergic Reactions:				
Seizures ☐ Yes ☐ No	**Type:**	**Frequency:**	**Approximate Duration:**	
Recommended Response to Seizure Activity:				
Medical Monitoring:	**Lab Work/Blood Levels: (frequency)**	**Blood Pressure: (frequency & parameters)**	**Bowel Movements:**	**Other: (specify)**
Vision Aids:		**Hearing Aids:**		**Dental Appliance:**
Protective Devices:		**Purpose:**		
Instructions for use:				
Other Individualized Health Care Routines:				

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DIET				
Food:	**Independent with all utensils?** ☐ Yes ☐ No	**Independent with specific utensils?** ☐ Yes ☐ No	**Requires limited assistance?** ☐ Yes ☐ No	**Requires significant assistance?** ☐ Yes ☐ No

Consistency of food: (check as applicable)	**Normal**	**Chopped**	**Pureed**	**Other:**	**Does this individual present a choking hazard?** ☐ Yes ☐ No

Special Diet: (describe)

Beverages:	**Independent with cup/glass?** ☐ Yes ☐ No	**Independent with adaptive container?** ☐ Yes ☐ No	**Requires limited assistance?** ☐ Yes ☐ No	**Requires significant assistance?** ☐ Yes ☐ No

Independent in obtaining or requesting beverages: ☐ Yes ☐ No	**System for fluid intake** (if applicable):

Describe Adaptive Eating & Drinking Equipment:

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COMMUNICATION					
Communication Skills: (as applicable)	**Uses Complex Sentences**	**Uses Simple Sentences**	**Signs**	**Nods Yes/No**	**Gestures**
Describe Augmentative Communication Devices:					

MOBILITY				
Balance While Standing:	**Excellent** (not an issue)	**Moderate** (stumbles, etc.)	**Poor** (very unsteady; falls)	**Utilizes adaptive aids for balance**

Independent Mobility: (Check as applicable)	**Crawling/scooting**	**Kneeling**	**Standing**	**Walking**	**Running**	**Climbing**

Mobility/ Balance Aids:	**N/A**	**Walker**	**Cane**	**Crutches**	**AFOs**	**Leg Braces**	**Wheelchair**	**Other** (specify):

Positioning Instructions:
Lifting/Carrying Instructions:
Other Adaptive Equipment &/Facility Adaptations:

PERSONAL CARE SKILLS				
(Check as appropriate)	**Independent**	**Requires prompting or reminding only**	**Requires limited assistance or supervision**	**Requires significant assistance**
Dressing				
Toileting				
Bathing				
Dental Care				
Menses				
Other				
If applicable, describe special personal care needs & preferences:				

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INDIVIDUAL NEEDS

Name _____ **Name of Assessor** _____ **Date** _____

BEHAVIORAL CONCERNS		
Brief Description	**Approximate Frequency**	**Recommended Intervention**
Aggression		
Self-Injurious Behavior		
Property Destruction		
Eating Disorder		
AWOL		
Self Stimulation		
Sexual Acting Out		
Other		
Is Behavior Treatment Plan available for additional information? ☐ Yes ☐ No		**Reason for BTP:**