**SYNAPSE HOUSE**

**2025 INDIVIDUALIZED SERVICE PLANNING FORM – 6.01.E**

**Name: Date: Initial, Reassessment or Annual**

* Synapse House works with you to develop the Individualized Service Plan (ISP)
* This is started at the time of admission and reviewed every six months.
* You may modify your plan as needed.
* To achieve the best outcomes, we recommend participating 2-3 times per week.
* This is your plan and your program. Active participation is required to make the changes you want.
* Discuss with our staff your concerns or ideas to better help you or if you want to change the direction of your plan.

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| **What do you want to achieve overall?** |  |
| What should we know about you? |  |
| What should we know about your injury, stroke or condition? |  |
| What steps do you want to take to meet your goals? |  |
| What are the areas of difficulty? |  |
| What are your strengths? |  |
| What are your abilities? |  |
| What are your preferences? This may be related to your religion, beliefs, culture or just your likes and dislikes. |  |
| Any other medical history we should know?  Please keep us updated on any medication changes or medical condition changes. |  |
| Any psychological history to know or approaches we should take to make for your mental health & wellness? |  |
| Who are the people in your support system or other social information to know? |  |
| What information should we know about how you function in the activities you need to do? |  |
| Where did you have therapy before? What kind? |  |
| Are you in therapy now? If so, where and what kind?  Please notify us of any therapies you receive.  **One strategy, one technique, one approach should be utilized across all the systems.** | THIS IS CRITICAL – If you are receiving therapy or behavioral services, Synapse House should follow the same plans (i.e. memory strategies, transfers or behavioral approaches). This is for your benefit. The more the skill is practiced in the same way, the more success you will have. |
| What is any health or safety risks?  (i.e. medication side effects, seizure triggers, fall risks)  THIS CANNOT BE BLANK |  |
| What can we do to reduce these risks?  THIS CANNOT BE BLANK |  |

**Family & Caregiver Section**

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| What do you want your family member to achieve? |  |
| How can we help you, the family members, or caregivers on this journey? We want to set a goal each year to help support you. |  |