It's My Life Kamloops Society

IMKS

ADMISSION AND INTAKE INFORMATION

Service requested/ accessing: _____

Name: _____

Phone: _____ Date: _____

Address: _____

City: _____ Postal Code: _____

Birthdate: _____ Age: _____

Admission Date_____

First Nations: Yes___ No___ Band: _____ Status: Yes___ No ___

Family Contact: _____ Phone: _____

Emergency Contact _____ Phone: _____

CLBC Contact: _____ Phone: _____

Outreach or Community Inclusion: _____Phone: _____

Employed: Yes ___ No___ If yes, where _____

_____

Temporary Substitute Decision Maker: Yes___ No___ If yes, who _____

_____

Legal System Involved: Yes___ No___ See Legal Status Sheet attached.

Diagnosis: _____

Smoker: Yes___ No___

Physician: _____Phone: _____

Care Card # _____

SIN # _____

Dentist: _____ Phone: _____

Psychiatrist: _____ Phone: _____

DDMH_____ Phone: _____

Neurologist: _____Phone: _____

List other professionals involved:

_____ Phone: _____

_____ Phone: _____

_____ Phone: _____

History of Mental Health Problems: Yes ___ No___

If yes, please describe: _____

_____

_____

_____

_____

_____

Medical Problems/ Conditions: _____

_____

_____

_____

_____

Health Care Plan? Yes___ No ___ Please attach HSCL involved:

Medications: ***Use reverse side or attach another piece of paper if not enough room***

BEHAVIOUR:

HISTORY OF BEHAVIOURAL CONCERNS:

Please check any of the following and explain it if applicable.

Violence towards: Peers___ Adults___ Children___ Animals___ Property___ N/A ___

If any were checked, explain: _____

_____

_____

Suicide: Attempts ___ Threats ___ N/A ___

If any were checked, explain: _____

_____

_____

Sexual Acting Out: Peers ___ Adults ___ Children ___ Others ___ N/A ___

If any were checked, explain: _____

_____

_____

Self- Injuries: Yes ___ No ___

If yes, explain: _____

_____

_____

Elopement: Yes___ No___

If yes, explain: _____

_____

_____

Non- Compliance ___ Defiance ___ Oppositional ___ N/A ___

If any were checked, explain: _____

_____

_____

UNUSUAL BEHAVIOUR WHICH REQUIRE SPECIFIC APPROACHES (please include risk behaviours) If BSP in place, please attach and bypass below

Behaviour: _____

_____

Approach: _____

_____

Behaviour:_____
_____
Approach:_____
_____
Behaviour: _____
_____
Approach: _____
_____

ALERTS: including risks and safety concerns for individual and Support staff

_____
_____
_____

ACTIVITIES FOR DAILY LIVING:

Communication: Speech Signing PIC Symbols Others: _____

Food/ Beverage Allergies: _____
_____

Food Dislikes: _____
_____

Food Likes: _____
_____

Food/ Beverages will eat excessively: _____
_____

Feeding Ability: Self ___ Partial Assistance ___ Total ___

Please add any other relevant information about eating: (i.e choking, uses special eating aids, etc.)

_____
_____

DAILY LIVING SKILLS:

I- Independent GP- Gestural Prompt PP- Physical Prompt

VP- Verbal Prompt HH- Hand over Hand NS- No Skill

Fork: ___ Plate: ___ Glass: ___ Cup: ___ Knife: ___ Spoon: ___ Bowl: ___

HYGEINE

Dress Self: ___ Shoes: ___ Jacket: ___ Uses Toilet: ___ Wipe Self: ___

Washes Hands: ___ Brushes Teeth: ___ Flosses Teeth: ___ Showers/ Bath: ___

Washes Hair: ___ Applies Deodorant: ___

Incontinence: Yes No Sometimes Needs Reminders: Yes No Sometimes

Depends: Yes No Assistance Required: Yes No

Mobility: Good Fair Poor Uses Mobility Aids: Yes No

If yes, please describe (uses cane, leg brace, wheelchair, etc.)

_____

_____

What assistance is required with mobility: _____

_____

SLEEP HABITS:

Usual Bedtime: _____ Usual Awake Time: _____ Up During Night? _____

Regular Bedtime Routine: _____

_____

_____

_____

_____

ACTIVITY INFORMATION:

Favourite Activities: _____

_____

_____

Activities Individual Dislikes: _____

_____

_____

Fears (does client have any fears i.e.: dark, specific animals, noises, personal space, belongings being touched, etc.): _____

_____

Traffic Awareness: (what skill level does the client have)
Independent _____ Some Skill _____ No Skill _____
Please describe what traffic safety skills the client needs assistance with:

_____

_____

_____

Please indicate other relevant information:

_____
_____
_____

Please describe individual's abilities in the following areas:

Use of stove: _____
_____
_____
_____

Use of dishwasher: _____
_____
_____
_____

Ability to follow a recipe: _____
_____
_____
_____

Cooking skills: _____
_____
_____
_____

Household cleaning skills: _____
_____
_____
_____

Grocery shopping skills: _____
_____
_____
_____

Money skills: _____
_____
_____
_____

Bus transportation skills: _____
_____
_____
_____

What does a typical week look like:

MONDAY: _____

TUESDAY: _____

WEDNESDAY: _____

THURSDAY: _____

FRIDAY: _____

SATURDAY: _____

SUNDAY: _____

SIGNIFICANT OTHERS PHONE CONTACT INFORMATION

Name: _____ Phone: _____
Name: _____ Phone: _____
Name: _____ Phone: _____
Name: _____ Phone: _____
Name: _____ Phone: _____
Name: _____ Phone: _____
Name: _____ Phone: _____
Name: _____ Phone: _____
Name: _____ Phone: _____
Name: _____ Phone: _____

EMERGENCY MEDICAL FACE SHEET

Attach to Emergency and Evacuation Face Sheet

Name: _____ Address: _____ DOB: _____

Personal Health Number: _____

Physician: _____

Temporary Substitute Decision Maker: _____

Contact Person: _____ Phone: _____

Diagnosis: _____

Medical Conditions/ Concerns: _____

_____

Allergies: _____

Medications: _____

_____

_____

Special Medication Administration Instructions: _____

_____

Risk Alerts: Yes ____ No ____ *specify* _____

_____

_____

Behavioural Concerns: Yes ____ No ____ *specify* _____

_____

_____

Communication Difficulties: Yes ____ No ____ *specify (how receptive and expressive language is expressed, non verbal, hearing impaired, pic symbols, sign, etc.)* _____

_____

_____

Other pertinent information: _____

_____

_____

_____

#308 444 Victoria Street, Kamloops BC, V2C 2A7 Phone: 250- 3777- 7661 Fax: 250- 377-7660

DAILY CARE PLAN

NAME:

DATE:

Daily Routine

From when the individual wakes up until bedtime.

#308 444 Victoria Street, Kamloops BC, V2C 2A7 Phone: 250- 3777- 7661 Fax: 250- 377-7660

Personal Hygiene:

Bathing:

Shave:

Toileting:

Teeth:

Skin Care:

Nails:

Eyes:

Ears:

Health

Diet:

Exercise:

Illness:

Medication Administration:

Sleep Patterns:

Sexuality:

Communication:

Other

Safety in the home/ Community:

Transportation:

Traffic Awareness:

Fire and Emergency Drills:

Public Conduct:

Recreation/ leisure:

Socialization:

Time Concept:

Money Management:

Personal Awareness:

Adapting to Community Living:

Clothing:

Include preferences and sizes