ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Division of Developmental Disabilities

PRE-SERVICE PROVIDER ORIENTATION

INSTRUCTIONS: This form is to be completed by the provider and the individual and/or responsible party receiving services prior to the initiation of services. A copy MUST be retained by the provider and a copy sent to the District Office. The provider must also ensure that a General Consent and Authorization form is completed and retained by the provider.

PROVIDER INFORMATION

Provider's Name *(Last, First, M.I.)* _____

Employer Tax No _____ AHCCCS ID No _____

Is there any special training required? Yes No Describe: _____

Med Training Needed Yes No Seizure Management Training Needed Yes No

CRITICAL INFORMATION

Individual's Name *(Last, First, M.I.)* _____

Assists No. _____ Birthdate _____

Individual's Address *(No., Street)* _____

City _____ State _____ ZIP Code _____

Guardian's/Responsible Party's Name *(Last, First, M.I.)* _____

Relationship _____ Phone Number _____

Address *(No., Street)* _____

City _____ State _____ ZIP Code _____

Emergency Contact's Name *(If other than responsible party)* _____

Relationship _____ Phone Number _____

Support Coordinator's Name _____

Office Location _____ Phone Number _____

Name of ALTCS/DDD Health Plan _____

AHCCCS ID No. _____ Phone Number _____

Primary Care Physician's Name _____ Phone Number _____

Address *(No., Street)* _____

City _____ State _____ ZIP Code _____

Urgent Care Facility's Name _____ Phone Number _____

Address *(No., Street)* _____

City _____ State _____ ZIP Code _____

Other Health Insurance Information _____

DAY PROGRAM *(If applicable)*

Name of Day Program _____ Program Type _____

Days and Hours of Attendance _____ Transportation Method _____

Day Program Address *(No., Street)* _____

City _____ State _____ ZIP Code _____

Phone Number _____

See page 4 for EOE/ADA/LEP/GINA disclosures

HEALTH-MEDICAL

CURRENT MEDICATIONS AND SIGNIFICANT HISTORICAL ISSUES:

Med Log Required Yes No

Special Medication Instructions

ALLERGIES TO:

Food Yes No Specify _____

Medication Yes No Specify _____

Bee Stings Yes No Specify _____

Other Yes No Specify _____

Recommended Response to Allergic Reaction

_____

SEIZURES:

Yes No Describe _____

Frequency _____ Approximate Duration _____

Recommended Response to Seizure Activity

_____

ASSISTIVE DEVICES:

Vision _____ Hearing _____ Dental Appliances _____

PROTECTIVE DEVICES:

Instructions for Use

Purpose _____

Other Individualized Health Care Routines

PRE-SERVICE PROVIDER ORIENTATION

Individual's Name *(Last, First, M.I.)* _____

Assists No. _____ Birthdate _____

DIET

FOOD:

Independent with Utensils Yes No

Independent with Specific Utensils Yes No

Requires Limited Assistance Yes No

Requires Significant Assistance Yes No

Does Food Present A Choking Hazard Yes No

Required Consistency of Food Normal Chopped Puréed

SPECIAL DIET

Tube Feeding *(Special instructions required)* Yes No _____

Eating Disorder *(Describe)* Yes No _____

BEVERAGES:

Independent with Any Cup/Glass Yes No

Independent with Adaptive Yes No

Requires Limited Assistance Yes No

Requires Significant Assistance Yes No

Independent in Obtaining/Requesting Beverages Yes No

Describe adaptive eating/drinking equipment _____

Describe if Special Liquid Intake Needs _____

System for Fluid Intake *(If applicable)* _____

COMMUNICATION

COMMUNICATION SKILLS: *(Check as applicable)*

Uses complex sentences Uses simple sentences Signs Nods yes/no Gestures

Describe Augmentative Communication Devices *(If applicable)* _____

MOBILITY

BALANCE WHILE STANDING:

Excellent *(not an issue)* Moderate *(e.g.,stumbles)* Poor *(e.g., very unsteady, falls)*

Utilizes Adaptive Aids for Balance Yes No

Independent Mobility *(Check as applicable)*

Crawling/Scooting Kneeling Standing Walking Running Climbing

Mobility/Balance Aids *(Check as applicable)*

N/A Walker Cane Crutches AFOs Leg Braces Wheelchair Running Climbing

Other *(Specify)* _____

Positioning Instructions _____

Lifting/Carrying Instructions _____

PERSONAL CARE SKILLS *(Check all applicable items)*							
	Dressing	**Toileting**	**Bathing**	**Dental Care**	**Menses**	**Med. Admin**	**Other**
Independent							
Requires Prompting/Reminding							
Requires Limited Assistance/ Supervision							
Requires Significant Assistance							
IF APPLICABLE, DESCRIBE SPECIAL PERSONAL CARE NEEDS AND PREFERENCES							

BEHAVIORAL CONCERNS *(If applicable)* CIT Training Yes No		
BRIEF DESCRIPTION	**APPROXIMATE FREQUENCY**	**RECOMMENDED INTERVENTION**
Aggression		
Self-Injurious Behavior		
Property Destruction		
AWOL		
Self-Stimulation		
Sexual Acting Out		
Other		

Is a Behavior Treatment Plan (BTP) Available for Additional Information Yes No

Reason for BTP _____

Method Used to Obtain Information *(e.g., in person, case file)* _____

SIGNATURES

Signature of Person Completing if Not Responsible Party _____

Relationship _____ Date _____

Print Provider's Name _____

Provider's Signature _____ Date _____

Print Responsible Person's/Guardian's Name _____

Responsible Person's/Guardian's Signature _____ Date _____

Distribution: Copy – Provider; Copy – District Office; Copy – Parent/Guardian; Copy – Support Coordinator