Mille Lacs County Area DAC

ADMISSION FORM AND DATA SHEET

*This form is completed at service initiation and update as needed. Dated signatures are obtained at initiation and when changes are made.

PERSONAL INFORMATION	
Name:	Date of birth:
Address:	Home telephone number:
Cell phone number:	Email address:
Date of admission or re-admission:	Language(s) spoken:
Guardianship type (self, private, public):	Religious preference:
Marital status:	Other:

IDENTIFYING CHARACTERISTICS	
Gender:	Race:
Height:	Weight:
Hair color:	Eye color:
Distinguishing characteristics/identifying marks:	

FINANCIAL INFORMATION	
Social Security Number (SSN):	Medical Assistance Number:
County of responsibility:	PMI number:
County of financial responsibility:	Burial account number:

MEDICAL INFORMATION	
Diagnoses:	
Allergies:	
Protocols (seizure, diabetic, etc.):	
Medical equipment, devices, or adaptive aides or technology used:	Specialized dietary needs:

GENERAL CONTACT INFORMATION	
Name	**Address and telephone numbers**
Legal representative:	
Authorized representative:	

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Primary emergency contact:	
Case manager:	
Family member:	
Family member:	
Other:	
Financial worker:	
Residential contact:	
Vocational contact:	
Other service provider:	

HEALTH-RELATED CONTACT INFORMATION	
Name	**Address and telephone numbers**
Primary health care professional:	
Psychiatrist:	
Other mental health professional:	
Neurologist:	
Dentist:	
Optometrist/Ophthalmologist:	
Audiologist:	
Pharmacy:	
Hospital of preference:	
Other health professional:	
Other health professional:	

_____ _____

Person served and/or legal representative Date

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Individual Abuse Prevention Plan (IAPP)

Person's Name:

Program:

A. Sexual abuse

Is the person susceptible to abuse in this area? ☐ Yes (if any area below is checked) ☐ No

- ☐ Lack of understanding of sexuality
- ☐ Likely to seek or cooperate in an abusive situation
- ☐ Inability to be assertive
- ☐ Other:

Specific measures to minimize risk of abuse for each area checked:

Referrals made when the person is susceptible to abuse outside the scope or control of this program (Identify the referral and the date it occurred).

B. Physical Abuse

Is the person susceptible to abuse in this area? ☐ Yes (if any area below is checked) ☐ No

- ☐ Inability to identify potentially dangerous situations
- ☐ Lack of community orientation skills
- ☐ Inappropriate interactions with others
- ☐ Inability to deal with verbally/physically aggressive persons
- ☐ Verbally/physically abusive to others
- ☐ "Victim" history exists
- ☐ Other:

Specific measures to minimize risk of abuse for each area checked:

Referrals made when the person is susceptible to abuse outside the scope or control of this program (Identify the

referral and the date it occurred).

C. Self Abuse

Is the person susceptible to abuse in this area? ☐ Yes (if any area below is checked) ☐ No

- ☐ Dresses inappropriately
- ☐ Refuses to eat
- ☐ Inability to care for self-help needs
- ☐ Lack of self-preservation skills (ignores personal safety)
- ☐ Engages in self-injurious behaviors
- ☐ Neglects or refuses to take medications
- ☐ Other:

Specific measures to minimize risk of abuse for each area checked:

Referrals made when the person is susceptible to abuse outside the scope or control of this program (Identify the referral and the date it occurred).

D. Financial Exploitation

Is the person susceptible in this area? ☐ Yes (if any area below is checked) ☐ No

- ☐ Inability to handle financial matters
- ☐ Other:

Specific measures to minimize risk of abuse for each area checked:

Referrals made when the person is susceptible to abuse outside the scope or control of this program (Identify the referral and the date it occurred).

E. Is the program aware of this person committing a violent crime or act of physical aggression toward others? ☐

Yes ☐ No

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Specific measures to be taken to minimize the risk this person might reasonably be expected to pose to visitors to the program and persons outside the program, if unsupervised:

Referrals made when the person is susceptible to abuse outside the scope or control of this program (Identify the referral and the date it occurred).

An individual abuse prevention plan is developed for each new person as part of the initial service plan. The person will participate in the development of the plan to the full extent of their ability. When applicable, the person's legal representative will be given the opportunity to participate with or for the person in the development of the plan. The interdisciplinary team will document the review of the plan at least annually, using an individual assessment, as required in MN Statutes, section 245D.071, subd. 3, and any reports of abuse relating to the person. The plan shall be revised to reflect the results of this review.

Signatures of those reviewing and/or participating in the development of this plan

Name	Signature	Title	Date
		Person completing IAPP	
		Person	
		Legal Representative	
		Case Manager	
		Program Representative	

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ANNUAL PHYSICAL EXAMINATION

Name:_____ Date: _____

Referred to (licensed health care professional): _____

Level of supervision:
24 hour staffing on site Overnight sleep staff Overnight awake staff Shift staff on site (less than 24 hours per day)

DOB:_____ Allergies:_____ Diet:_____

Diagnoses:_____
_____

Current medications and doses: (Attach List) Purpose:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Current treatments: Purpose:

_____ _____
_____ _____
_____ _____
_____ _____

Health concerns:_____
_____
_____

EXAMINATION RESULTS:
The annual physical assessment is to include a physical examination, hearing and vision screening, CBC, urinalysis, chest x-ray or mantoux, pap smear, and a review of the medical treatment plan.

Height:_____ Weight:_____ Ideal Weight Range:_____
Temp.:_____ Pulse:_____ Blood Pressure:_____

Review of Systems:
Skin:_____ Lymph Nodes:_____
Eyes: (R)_____ (L)_____ Ears: (R)_____ (L)_____
Nose:_____ Throat:_____ Mouth:_____
Neck:_____ Lungs:_____
Heart:_____ Breasts:_____
Abdomen:_____ Extremities:_____
Genito-Urinary:_____ Ano-Rectal:_____
Posture:_____ Gait:_____
Nervous System:_____
Fine Motor:_____ Gross Motor:_____
Note any physical abnormality:_____

Are there any medical or psychological contraindications to the use of staff implemented manual restraint to protect this person, when a person's conduct poses an imminent risk of physical harm to self or others and less restrictive strategies would not achieve safety? ☐ **Yes** ☐ **No**

If yes, what are they and are there any special adaptations or precautions staff may take to still use manual

restraint in dangerous circumstances (list on next page)?

_____

_____

Vision Screening: Results:_____

Is a more thorough vision exam recommended? ☐ Yes ☐ No

Hearing Screening: Results:_____

Is a more thorough audiology exam recommended? ☐ Yes ☐ No

Note any problems with speech and language:_____

_____

Is referral to a speech/language therapist indicated? ☐ Yes ☐ No

Laboratory Data: The following lab tests are requested, please attach copies of all results:

	Date Administered	**Notes/Results:** If test not administered, please list rationale
Cholesterol		
A1-C		
LFT		
CBC		
Urinalysis		
Mammogram		
Pap Smear		
Other_____		

Chest x-ray	or Mantoux given:	Location of Mantoux:
Date read:_____		Results:_____

Diphtheria-Tetanus shot given? ☐ Yes ☐ No Date of last Diphtheria-Tetanus shot: _____

I find this individual to be free of communicable disease: ☐ Yes ☐ No

General health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Summary of exam and diagnosis:_____

_____

_____

Treatment plan (new orders):_____

_____

Medications (new orders):_____

_____

Is individual capable of administering own medications? ☐ Yes ☐ No

Please Note:

1. All medications and treatments will be ordered for 1 year unless stop and start dates are indicated.
2. Your signature indicates you have reviewed these findings with the person/staff present.
3. Please provide instruction on when and to whom to report the following:
   a. Occurrence of adverse reactions to medications or treatments
   b. Medication not being administered or treatment performed as prescribed, whether by error of staff or refusal by the person
   c. Report to and when:

_____

_____

_____

_____

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Please call medication changes to our pharmacy _____ Phone:_____ Fax:_____

Physician signature: _____ Date: _____

Reviewed by: _____ Date: _____
Staff signature

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STANDING ORDER MEDICATION LIST			
Name:			
Symptoms	**MD OK**	**Medication**	**Special Instructions**
Fever, pain, headache, dental pain, menstrual cramps	Yes / No	**Acetaminophen/Tylenol** two 325 mg tabs or caps by mouth every 4-6 hours as needed. Do not take more than 12 tabs or caps in a 24 hour period. **or Acetaminophen/Tylenol** two 500 mg tab or cap by mouth every 6 hours as needed. Do not take more than 6 tabs or caps in a 24 hour period. For liquid acetaminophen, see package instructions for dosing.	**Notify health care professional** of temp. over 100°F or under 97.6°F, if fever lasts for longer than a 24 hour period, if individual is on new or recently increased antipsychotic medication, or has a sore throat or congestion. **Notes:** *Do not exceed 3000 mg of acetaminophen in a 24 hour period. *Severe liver damage may occur if 4000 mg of acetaminophen is taken. *Fever can increase seizure activity in individuals with epilepsy.
*For elevated temperature/fever, do not administer medications for longer than one 24 hour period without consulting health care professional for further direction.	Yes / No	**Ibuprofen** two 200 mg tabs or caps by mouth every 6 hours as needed. For liquid Ibuprofen, see package instructions for dosing.	To prevent stomach upset, wait at least 90 minutes after Tylenol dose before giving Ibuprofen. Do not give Ibuprofen if individual is taking Lithium, daily aspirin doses, or blood thinning medications (Coumadin). Give with food or milk to reduce stomach upset. **Notify health care professional** if stomach upset occurs.
Pain/Fever	Yes/ No	**Naproxen** Sodium 220 mg orally every 8 hours as needed. Do not exceed 2 caplets in any 8- to 12-hour period	Naproxen is used to treat pain or inflammation caused by conditions such as arthritis, ankylosing spondylitis, tendinitis, bursitis, gout, or menstrual cramps.
Pain/Fever	Yes / No	**Aspirin** one or two 325 mg tablets every four hours. Not to exceed 12 tablets in a 24 hour period.	For temporary relief of headache, pain and fever of colds, muscle aches & pains, menstrual cramps, toothache pain, & minor aches and pains of arthritis.
Cough	Yes / No	**Robitussin** 2 tsps by mouth every 4 hours as needed. **or Mucinex 600 mg** 1 tab by mouth every 12 hours with 8 oz water. **Diabetic Individuals: Diabetic Tussin** 2 tsps by mouth every 4 hours as needed.	**Notify health care professional** if no relief or if medication has been used for 3 consecutive days. Do not use with individuals on MAOI medications (ex. Nardil, Parnate, Marplan). Do not substitute Ny-quil.
Stomachache, heartburn, upset stomach	Yes / No	**225 mg aluminum hydroxide and 200 mg magnesium hydroxide/ Maalox** 1 tbsp (15cc) by mouth every 3-4 hours as needed (up to 4 times in 24 hours).	Do not give with other oral medications unless instructed by health care professional or MD. **Notify health care professional** if no relief.

		or 500 mg calcium carbonate/ Tums 1-2 tabs chewed thoroughly every hour as needed (up to 10 tabs each day).	
Diarrhea	Yes / No	Do not administer until the person has had 3 loose stools. Then give **Loperamide/Immodium** two 2 mg caps after loose stool, one 2 mg cap after each subsequent loose stool. **Do not exceed 4 doses in 24 hours.**	**Notify health care professional** and follow directions as given. Encourage fluids.
Sunburn protection	Yes / No	Liberally apply sunscreen with a SPF of 30 or higher to exposed skin ½ hour prior to exposure.	Re-apply every 2 hours or sooner if sweating or swimming. Seek shade at first sign of pinkness developing on skin from sun burning. **Notify health care professional** if sunburn occurs.
Sunburn	Yes / No	**Aloe Vera Gel** as directed by packaging.	**Notify health care professional immediately** if blisters are present.
Sore throat or canker sores	Yes / No	**Chloraseptic** lozenges, one by mouth every 2 hours as needed. **or Chloraseptic** throat spray, 5 sprays every 2 hours as needed.	For sore throat, take individual's temperature. **Notify health care professional** if temp. over 100°F. Encourage fluid intake.
Poisoning or overdose	Yes / No	Contact Poison Control.	**Notify health care professional.**
Hard stools	Yes / No	**Docusate Sodium/ Colace** 100 mg cap by mouth once a day as needed.	**Notify health care professional** if no results occur within 2 days.
Hemorrhoids	Yes / No	Gently clean affected area and pat dry. Then use: **Tucks** pads, apply topically by blotting affected area with one pad up to 6 times a day as needed. **or Hydrocortizone Acetate/ Anusol HC-1** cream/ointment, apply topically to affected area 3-4 times a day as needed. **or Preparation-H** cream/ointment, apply topically to affected area up to 4 times a day as needed.	**Notify health care professional** for rectal bleeding, blood in stool, tar colored stools, or stool that looks like coffee grounds.
Constipation	Yes / No	**Milk of Magnesia** 1 oz (30 cc) by mouth as needed **or Psyllium Fiber/Metamucil** 1 rounded tsp in 6-8 oz of juice or water up to 3 times a day as needed **or Metamucil wafers** two wafers up to 3 times a day	Milk of Magnesia produces faster results. Metamucil will need to be given for 2-3 days to produce desired effect. **Notify health care professional** if no results occur within 2 days. **Note:** Diabetic individuals need to receive **sugar free** Metamucil.
Nausea/vomiting	Yes / No	Encourage clear liquids (ex. ginger ale, broth) and avoid milk.	**Notify health care professional** and follow directions as given.

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Congestion	Yes / No	**Saline Nasal Spray** 2 sprays each nostril up to every 2 hours as needed. **or Vicks Vapo Rub** topically underneath nose or to chest.	Do not share nasal spray with others. **Notify health care professional** if no relief in 2 days.
Earwax softening	Yes / No	**Carbamide Peroxide/Debrox** 5-10 drops twice daily in affected ear as directed by health care professional **administration of 50% peroxide/ 50% water** to ear for irrigation.	**Notify health care professional** if no relief in 3-4 days. Do not use if ear pain is present or if draining fluid.
Dandruff	Yes / No	**Selenium Sulfide/Selsun Blue or Neutrogena T-Gel** use 2-4 times a week.	Shake shampoo well before using. Rinse well and avoid eyes. May temporarily discolor hair.
Dry lips, fever blisters, cold sores	Yes / No	**Medicated Lip Balm** applied topically to affected area up to 4 times a day as needed.	**Notify health care professional** if cold sores occur more than once a month. Do not share with other individuals.
Minor wound care	Yes / No	**Notify health care professional and follow directions** Cleanse wound with soap and water and pat dry, then apply **Bacitracin**, **Neomycin** or **Triple Antibiotic** ointment/cream to wound 3 times a day.	Do not use these medications on newly burned areas. Apply medication in a thin layer. Do not use on deep puncture wounds unless directed by a physician. **Notify health care professional or physician** if signs of infection appear (increased redness, swelling, pus, fever, or increased warmth at wound site).
Minor skin irritation or itching	Yes / No	**Notify health care professional and follow directions** **Hydrocortisone 1%** cream/ointment to affected area up to 3 times a day	Apply to clean, dry skin. Do not apply to area larger than 10" by 10", avoid eye, eyelid, and mouth area. **Notify health care professional** if no improvement after 3 days.
Insect bite prevention	Yes / No	Use repellents as directed on container.	Avoid eye and mouth area when applying. Wash hands before eating or smoking.
Dry skin	Yes / No	OK to use any non-medicated lotion.	Use Vaseline for severely dry skin.
Dental pain	Yes / No	**Notify health care professional and follow directions** **Ambesol Regular Strength, Liquid or Gel (Benzocaine 10%).** **or Orajel Mouth Aid Regular Strength, Liquid or Gel (Benzocaine 10%).** Apply small amount to applicator and swab affected tooth. Do not exceed 4 doses in 24 hours.	Contact Dentist for an appointment. Do not use medication for longer than 7 days. Discontinue use if fever, rash, or swelling develops or if pain, redness or irritation intensifies. Do not use if allergic to other "-caine" meds, such as lidocaine. Do not swallow. This medication can affect swallowing and gag reflexes-use choking precautions.
Influenza Prevention	Yes / No	Influenza Virus Vaccine intramuscularly annually October through January.	Do not give if allergic to chicken eggs, reaction history to previous flu vaccines, or Guillain-Barre Syndrome history. If the person is ill, wait until illness subsides to receive injection.
Other	Yes / No		

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Generic equivalents can be used for the above referenced medications.

Signature indicates authorization of generic or brand substitutes, unless otherwise indicated.

Licensed health care professional signature: _____

Date: _____

Orders are valid for 12 months from date signed unless otherwise indicated.

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AUTHORIZATION FOR MEDICATION AND TREATMENT ADMINISTRATION

Name: Date of birth:

If responsibility for medication and treatment administration has been assigned to this company in the *Coordinated Service and Support Plan* and/or *Coordinated Service and Support Plan Addendum*, the company will obtain written authorization from the person served and/or legal representative.

I authorize the company to administer the following:

☐ Routine prescribed medications	☐ Prescribed psychotropic medication
☐ Routine prescribed treatments	☐ Prescribed PRN psychotropic medication
☐ Standing Order Medications (as authorized by prescriber)	☐ Other, please specify:

Please describe any limitations, if any, to the above checked boxes:

I understand the following:

- I may refuse to authorize the company to administer medication or treatment and that the company will not administer the medication.
- This authorization will remain in effect unless withdrawn in writing and it may be withdrawn at any time.
- The company must notify the prescriber as expediently as possible if I refuse to authorize the administration of medication or treatment and any directives or orders given will be followed.
- A refusal to authorize the administration of a specific psychotropic medication is not grounds for service termination and does not constitute an emergency. A refusal to administer the psychotropic medication may not be overridden without a court order.
- This authorization will be obtained at service initiation before administering medications or treatments.
- This authorization will be re-obtained annually.

_____ _____

Person served and/or legal representative Date

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MILLE LACS COUNTY AREA DEVELOPMENTAL ACHEIVEMENT CENTER , INC .

REQUEST FOR PLACEMENT

As a representative of _____ County Social Service/Welfare Agency, I request that the following individual be placed for services as outlined in his/her Coordinated Service and Support Plan This placement is in accordance with our inter-agency Purchase of Service agreement dated _____

Client Name: _____

Address: (to determine if transportation is possible) _____

Case Manager: _____ Services to begin on or about: _____ Services to terminate _____ or at that time when the assigned Support Team determines that the placement is no longer appropriate.

Mille Lacs County Area DAC operates on a first-come, first-served basis. Please indicate the start date (above) and submit the following forms as soon as possible to determine if services are available.

The following forms comprise the admission packet. When completed, please return to Mille Lacs County Area DAC, P O Box 92, Milaca MN 56353

_____ Request for placement (this form) signed by case manager
_____ Admission Form and Data Sheet
_____ Guardian/Conservator Paperwork copies
_____ Admission Physical Examination with Manual restraint section completed
_____ Authorization for Medication and Treatment Administration
_____ Standing Order Medication List
_____ Work Evaluation
_____ Individual Abuse Prevention Plan
_____ Coordinated Service and Support Plan from Case Manager
_____ Reports of recently attended educational, DAC or other programs
_____ Incident Reports from most recent program attended
_____ Psychological Assessment including IQ, if available

THE FOLLOWING INFORMATION IS REQUIRED BEFORE A CLIENT MAY PARTICIPATE IN THE WORK PROGRAM : No one will be allowed to work until these forms are completed.

_____ I-9 (Department of Homeland Security) must be accompanied by required identification (example: original Social Security Card and driver's license or MN ID card)
_____ W-4

Signed: _____ Date: _____

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_____

JOB LOCATION

Work Evaluation

Client Information

Name		*Client #*	
Date		*Evaluator*	Work Area/
Jobs Worked			

Guidelines

	Yes, Usually	Sometimes, Partially	No, Rarely	No Opportunity	Unknown
Initiates work independently or with initial					
Comments					
Comments					
Performs all steps required to complete					
Comments					
Comments					
Comments					
Comments					
Seeks staff assistance when needed for					
Comments					
Comments					

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Recognizes when job is finished/completes					
Comments					
Demonstrates socially acceptable behavior					
Comments					
Comments					
Willingness/ refusal to work on specific tasks					
Comments					
Wears clothing appropriate for					
Comments					
Demonstrates safety skills					
Comments					
Safely uses chemicals					
Comments					
Safely uses equipment/machines					
Comments					
Unmet skills needed to perform at a competitive level					
Comments					

Additional Comments

Favorite jobs:
Work performed best:
Areas of growth for next year:
Comments:

Verification of Work Evaluation

Client Signature		**Date**	
Program Coordinator Signature		**Date**	

Revised JANUARY 2016