

FUTURES PLANNING PROCESS WORKSHEET (March 5, 2003)

This document is intended to serve as a summary of the preferences and needs as described by the individual, their family members, staff who know them well and other friends. Each assessment is individually conducted to gather important information about each person's preferred future living arrangement. Vocational and leisure interests are also assessed. The "Needs" section focuses on health needs, adaptive living skills, mobility, and other training areas. The purpose is to generate data for the Community Development Team to ensure that the proper resources are identified or developed in community settings. This is not to be construed as a comprehensive health or training assessment. For additional detail, please refer to the clinical record.

Consumer Information

Name _____ UCI # _____
Sex _____ DOB _____ Reg. Ctr. _____
Admission Status: 6500 HOP CAMR LPS _____ _____

Program/Family/Staff Information

Program/Residence _____ LOC: NF ICF Res. Mgr. _____
IPC _____ Work No. _____
Day No. _____
Parent/Advocate Name _____
Address _____
Phone _____

If Conserved, List Name(s) (Co-Conservators) _____
(If other than above) Address _____
Phone _____

Date Completed _____ Date Updated _____

Completed By _____
(Print Name and Title) Signature and Title

I. Review of Needs

Mental Retardation Level: Mild Moderate Severe Profound Autistic

Cerebral Palsy [Seizures Controlled; Freq. ___ IM O2 (If req. past 2 yrs)]

Neurology Services OT/PT Treatment (Specify if req. past 2 years)_____

Mental Health Diagnosis_____

Psychiatric Services; Number of Psychiatric Consults last 2 years _____

Dental/Clinic Sedation Previously Required.

List Significant Medical Conditions which Impact Daily Activities and Required Medical Equipment

HEALTH CONDITION	CURRENT	HISTORY LAST 2 YEARS	HEALTH CONDITION	CURRENT	HISTORY LAST 2 YEARS
Apnea	<input type="checkbox"/>	<input type="checkbox"/>	Colostomy Care/Ileostomy	<input type="checkbox"/>	<input type="checkbox"/>
Active, Communicable TB	<input type="checkbox"/>	<input type="checkbox"/>	Tracheostomy Care & Suctioning	<input type="checkbox"/>	<input type="checkbox"/>
Stage 1 or 2 Decubitus Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Naso-Gastric Feeding	<input type="checkbox"/>	<input type="checkbox"/>
Stage 3 or 4 Decubitus Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Insulin-Dependent Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>

Catheterization: Indwelling/Condom Self-Care Some Assistance Total Care

- Repositioning to Prevent Skin Breakdown/Contractures
- Special Assistance With Feeding
- O2 Therapy
- Intermittent Position Pressure Breathing
- Inhalation Assistive Devices (Specify) _____
- Recurrent Pneumonia (# of times in last 2 yrs.____)
- Recurrent UTIs (# of times in last 2 yrs____)
- Acute Hospitalizations:
(# of times in last 2 yrs.____ 96 VMC Other (specify_____)
- Infections VRE MRSA Other (specify_____)
- Staph or Serious Communicable Infections
- Fecal Impaction Removal, Enemas, or Suppositories
- Current Use of Side Rails Blind (Partial; Total) Deaf (Partial; Total)
- Allergies (Specify)_____

Equipment Needed: _____

List Other Significant Medical Conditions: _____

Medications

Mental Health Meds (Specify) _____

Routine Medical Treatments (blood pressure 1x weekly, monitor O2 saturation, skin treatments, routine injections, etc.). Specify: _____

Behaviors	Description	History of	Current	Impact
<input type="checkbox"/> Aggression:	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> High <input type="checkbox"/> Low
<input type="checkbox"/> Property Destruction	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> High <input type="checkbox"/> Low
<input type="checkbox"/> AWOL/Bolts/Wandering	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> High <input type="checkbox"/> Low
<input type="checkbox"/> Self Injurious	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> High <input type="checkbox"/> Low
<input type="checkbox"/> Pica	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> High <input type="checkbox"/> Low
<input type="checkbox"/> Compulsiveness	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> High <input type="checkbox"/> Low
<input type="checkbox"/> Sexually Inappropriate	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> High <input type="checkbox"/> Low
<input type="checkbox"/> Fire Setting	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> High <input type="checkbox"/> Low
<input type="checkbox"/> Other	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> High <input type="checkbox"/> Low
<input type="checkbox"/> Other	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> High <input type="checkbox"/> Low
<input type="checkbox"/> Other	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> High <input type="checkbox"/> Low

Antecedents/Precursors (List known for last 2 years) _____

- Highly Restrictive Interventions Required in Last Year Stat meds—Freq _____
- Floor containment—Freq _____ Forced Escort—Freq _____ Other _____—Freq _____

Mobility

- | | |
|--|--|
| <input type="checkbox"/> Ambulates Independently | <input type="checkbox"/> Able to Bear Weight |
| <input type="checkbox"/> Fragile Ambulator | <input type="checkbox"/> Transfers Independently |
| <input type="checkbox"/> Uses Walker | <input type="checkbox"/> Transfers With Assistance |
| <input type="checkbox"/> Uses Cane | <input type="checkbox"/> One-Person Lift |
| <input type="checkbox"/> Uses wheelchair | <input type="checkbox"/> 2 person lift |
| Type _____ | <input type="checkbox"/> Mechanical lift |
| <input type="checkbox"/> Oversized | <input type="checkbox"/> Other |
| When used _____ | |

Evacuation: Independent Alarm Verbal prompts Physical Prompts Total Care
 Cognitively Non-Ambulatory—would not evacuate without assistance.

Self-Help Skills

Toileting: Independent Habit trained Verbal prompts
 Physical prompts Total assistance

Incontinent: Day Night Bowel Bladder Pads/Briefs_____

Dressing: Independent Verbal prompts Physical prompts Total care

Hygiene: Independent Verbal prompts Physical prompts Total care

Eating: Independent Verbal prompts Physical prompts Total care

Dysphagia: Mild Moderate Severe

Bathing: Independent Verbal prompts Physical prompts Total care

Sleeping: Sleeps through night Awake Disruptive

Communication

Verbal Non-verbal Sign language Communicates pain

Expresses basic needs Adaptive device (specify)_____

Receptive: Understands basic needs/requests

Understands complex thoughts/ directions

Speech Therapy (Specify freq.) _____

Describe Current Work Program: _____

Describe Current Day Program: _____

II. Review of Living Arrangements and Preferences

Reporter (list name) _____

Please note whether the person providing information was the:

client, family member/support person/advocate, or staff person

Contact was in: Person Phone Letter Other _____

Preferences

A. Relationships

- Who is your best friends(s) currently?
- Who would you miss most if you were to leave?
- Is there any one you would want to continue to see/visit if you were to leave?
- Would you consider rooming with one of these individuals? Would you open to a new roommate?
- For family—Is it important to you to be in close enough proximity (distance) to your relative to visit routinely?

B. Work/Day Program and Services

- Are you happy with your current job/day program?
- What do you like or dislike about it; what would you change?
- If you currently receive a paycheck, would you like to continue doing so? How do you spend your money—outings, café, soda machines, cigarettes, etc.

C. Living Arrangement

- What do you like about your present living arrangement? What don't you like?
- If you were to live elsewhere, other than Agnews, what would that place have to be like?
- What are the most important things to consider in regards to where you live? With whom would you live? What type of setting—size and space considerations?
- If you did have an experience living in the community previously, what was good about that experience? What would you like to have seen changed or improved?

D. Location

- If you like living here, what is it about its location that appeals to you?
- Are there activities here, or proximity to services that are important—the campus, café, REACH, etc.?
- If you are only interested in another developmental center, please indicate why that would be important to you.

E. Community Resources—access to the following is important:

- What community resources have you already utilized? (shopping, movies, grocery stores, etc.)

- What others might you be interested in that you have not utilized in the past?
 - Of those community outings you've participated in over the past, what were your most favorite? Your least favorite?
 - Would being near public transportation be important to you?
 - Is being near access to emergency medical services an important factor to you?
- F. Other
- Is there anything else that is important to you that you would like to share?

Prioritization of the above—what are the more important points of those issues and preferences you've shared?

A—High Priority B—Important, But Not Essential C—Lower Priority