DDS RESPITE CENTER PACKET

Attachment A

Select REGION

REQUEST FOR RESPITE SERVICES

(Completed by case manager or service coordinator)

Request Date:

Name: _____ **DOB:** _____ **DDS #:** _____

Street: _____ **City/State:** _____ **Zip Code:** _____

Current Residence: ☐ Family Home ☐ CTH ☐ DCF Foster Home ☐ Other: _____

Family/Caregiver Name: _____ **Telephone:** (_____) _____

Street: _____ **City/State:** _____ **Zip Code:** _____

ISA: ☐ **NO** ☐ **YES** **If yes, ISA amount: $** _____ **ISA is for:** _____

Individual & Family Need Checklist Points: _____ **Residential WL Priority:0**

Respite Request for Select Center

Reason for this request: _____

List the exact dates and times:

	Location	Start Date	Time	AM/PM	End Date	Time	AM/PM
Choice #1	Click Here	_____	_____	☐AM/☐PM	_____	_____	☐AM/☐PM
Choice #2	Click Here	_____	_____	☐AM/☐PM	_____	_____	☐AM/☐PM
Choice #3	Click Here	_____	_____	☐AM/☐PM	_____	_____	☐AM/☐PM
Choice #4	ClickHere	_____	_____	☐AM/☐PM	_____	_____	☐AM/☐PM

Case Manager or Service Coordinator: _____

Office Location: _____

Telephone: _____

Please DO NOT write below this line

Authorization Status: ☐ Approved ☐ Denied ☐ Modified ☐ Pending

Comments:_____

_____

_____

_____

Family Respite Center Coordinator's Signature: _____

Date: ___ / ___ / ___

Cc: FRC, Ind. File, Respite File

Name: _____
DDS#: _____

Original Pre-visit
Center: _____Date: _____

DDS RESPITE CENTER PACKET
Select Region

GUEST PROFILE
(Completed by CM/SC or SDSW at Pre-Visit)

PLACE

PHOTO

HERE

Date: _____ D.O.B: _____ Nickname? _____

Hair Color: _____ Eye Color: _____ Height: _____ Wt: _____

Communication: Verbal: ☐ Non-Verbal: ☐ Religion: _____

Language spoken-understood, method, or device used:

Visually Impaired? Yes ☐ No ☐ Hearing Impaired? Yes ☐ No ☐

Level of Retardation: Mild ☐ Moderate ☐ Severe ☐ Profound ☐

Brief Medical Diagnosis: _____

Routine Medications? Yes ☐ No ☐ (refer to physician's orders)

If yes, how taken? _____

Seizures: Yes ☐ No ☐
If yes, describe type, frequency, and duration: _____

Allergies: Yes ☐ No ☐
If yes, please specify: _____

Describe feeding techniques used and adaptive equipment used:
_____

Food and Drink Issues:

Eats: Independently ☐ With Assist ☐ Fed ☐
Drinks: Independently ☐ With Assist ☐ Fed ☐
Utensils: Fork ☐ Knife ☐ Spoon ☐

Right handed? ☐ Left handed? ☐

Enjoys eating? Yes ☐ No ☐ Drinking? Yes ☐ No ☐

Portion sizes: _____

Diet: Regular: ☐ Special: ☐ If special, please specify: _____
Restricted: No ☐ Yes ☐ If yes, list restrictions: _____
Supplements: No ☐ Yes ☐ If yes, list restrictions: _____

Consistency of Food: Whole ☐ Cut ☐ Chopped ☐ Ground ☐ Pureed ☐
Consistently of Liquids: Thin ☐ Nectar ☐ Honey ☐ Pudding ☐

List Exceptions: _____
Typical Breakfast Foods:_____
Typical Lunch Foods: _____
Typical Dinner Foods: _____
Typical snack and approximate times eaten: _____

Favorites: _____
Dislikes: _____
Special Instructions: _____

Aspiration precautions:
_____

FOR INDIVIDUALS WHO ARE TUBE FED:
Tube Fed only? _____ Tube fed liquids only? _____ Tube fed with meds? _____ Tube fed as a supplement? _____

Liquids Thickened? _____ Additional information: _____

Cc: FRC, Ind. File, Respite File

Name: _____

DDS: _____

DDS RESPITE CENTER PACKET:
GUEST PROFILE

Adaptive/Special Equipment:
G-Tube ☐ Oxygen ☐ Tracheotomy ☐ Ostomy Appliance ☐ Nebulizer ☐ Other ☐ : _____
Glasses ☐ Hearing Aid ☐ Walker ☐ Wheelchair ☐ Seatbelt for Wheelchair ☐ Tray ☐ OT/PT ☐ Other ☐: _____
AFO's(describe): _____

Personal Care: **Check level of care and describe assistance and equipment required**
Grooming: Self ☐ With Assist ☐ Total Care ☐ _____
Dressing: Self ☐ With Assist ☐ Total Care ☐ _____
Bathing: Self ☐ With Assist ☐ Total Care ☐ _____
Toileting: Self ☐ With Assist ☐ Total Care ☐ _____

Bathing Support Required: No ☐ Yes ☐ If yes, check all that apply: **(please see attachment G for more information)**
Regulating water temperature and/or amount of water ☐ entering or leaving tub ☐ keeping head above water ☐ cleaning body ☐ drying and dressing ☐
Type of Supervision Required: Independent ☐, Continuous ☐, Frequent checks (amount of time person can be alone= ____ min)

Individual uses the toilet: No ☐ Yes ☐
Toileting Support Required: No ☐ Yes ☐
If yes, check all that apply: remove clothing ☐, getting onto toilet, ☐ personal hygiene afterwards, ☐.
If female, assistance during menses? No ☐ Yes ☐ N/A☐ If male, sits only on the toilet? No ☐ Yes ☐
Requires reminders for hygiene? _____
Diapered? Yes ☐ No ☐ At all times? Yes ☐ No ☐ Bed time only? Yes ☐ No ☐ Long trips only? Yes ☐ No ☐
Time tripped? Yes ☐No ☐ Tripping Schedule: Day time _____ Night time _____
Is there a constipation problem? No ☐ Yes ☐ **If yes, explain:** _____

Special instructions / Adaptive Equipment pertaining to Toileting: _____

Behavior and Socialization:

Behavioral Concerns: ***(check ☐ all that apply)***

Wanders ☐, Bolts ☐, Self-abuse ☐, Head butts ☐, Aggression to Environment ☐, Aggression to Others ☐, Bites ☐
Hits ☐, Kicks ☐, Mouths Objects ☐, Obsesses ☐, Verbally Abusive ☐, Screams ☐ Drops to Floor ☐, Steals Food ☐
Generally Non-Compliant ☐ Hyperactivity ☐ Depression ☐, Removes seatbelt during transportation ☐,
Grabs/Inappropriate Touches Others ☐, **PICA:** No ☐ **Yes** ☐ **(If yes, refer to attachment P)**
Hallucinations: *(Auditory ☐, Visual ☐, Tactile ☐)* Paranoid ☐, Tantrums ☐, Anxiety ☐,

Special Instructions/Restrictions Problems with noise or crowds: _____
What circumstances might encourage such behaviors? _____
Length of time behaviors usually persist: _____ min/hrs. Frequency: Day: _____ Week: _____
Major life changes related to behavioral concerns: _____
Behaviors to be encouraged: _____
Typical means of interaction with others: _____
Ethnic or Religious concerns/restrictions: _____
Smokes? _____ *(Explain any special guidelines, how much, how often, and when)* _____

Sleep Habits:
Bedtime: _____ Awakens: _____ Sleeps through?: _____ Awakens often?: _____ Frequency: _____
Type of Bed: _____ Bed rails: Yes ☐ No ☐ Night Light? Yes ☐ No ☐ Pads? Yes ☐ No ☐ Why? _____

Special instructions, favorite bedtime articles, rituals or problem areas associated with sleep: _____

Positioning Required?: Yes ☐ No ☐. If yes, explain reason position used and/or frequency (I.E. reflux means head of the bead must be increased) _____

Other: _____
Favorite Activities: At home: _____
In community: _____

Cc: FRC, Ind. File, Respite File

Name: _____

DDS#: _____

DDS RESPITE CENTER PACKET : GUEST PROFILE

Recommendations for peer group, sleeping accommodations, socializing, etc.: _____

PRE-VISIT COMMENTS/OBSERVATIONS:

Please check for any changes in the following information:

Parent/Guardian: _____ Day Phone#: _____
Address: _____ Eve. Phone#: _____
Case Manager: _____ Phone#: _____

Report Submitted by: _____

Date: _____

CC: CM/SC, FRCC, Nursing Staff, Respite File, Travel Packet 3/07

Name: _____

DDS#: _____

DDS RESPITE CENTER PACKET GUEST PROFILE
PROFILE UPDATES
(Completed by SDSW or Designee)

Date	Current Changes / Observations / Notations	Signature

Name: _____

DDS#: _____

Attachment C

DDS RESPITE CENTER PROGRAM
Select REGION

EMERGENCY AND AUTHORIZATION FORM
(Completed by CM/SC or SDSW)

Respite Center Phone ( ) _____-_____

EMERGENCY INFORMATION

Name:	DOB:	DDS#:
Address:		Phone#:
Parent/Guardian:		Day Phone#:
Address:		Eve. Phone#:
DDS Case Manager:		Phone:
Day Program:		Phone#:
Address:		
Emergency Contact (Other than parent/guardian):		Day Phone#:
Address:		
Primary Physician:		
Address:		Phone#:
Hospital Choice:	Address:	Phone#:
Neurologist:		
Address:		Phone#:
Psychologist/Psychiatrist:		
Address:		Phone#:
Dentist:		
Address:		Phone#:
Name of Insurance:	Policy Number:	
Pharmacy:		
Address:		Phone#:

MEDICAL AUTHORIZATION FORM
(Completed by Guest/Family member/Guardian)
Authorization for Medical Treatment

In the event that I cannot be reached, I hereby give consent for _____
(Physician/Medical Facility)

to provide medical care for _____D.O.B _____for treatment of illness or injury. If medication is prescribed, I hereby authorize: _____

_____ _____
(Name and Address of Pharmacy) **(Phone)**

_____
Insurance Name and Number)
To fill the prescription and charge my insurance.

_____ _____
(Signature of Consumer/Parent/ Legal Guardian) **(Date)**

DISCLOSURE

" I understand that door chimes may be used at the Respite Center to indicate when people may be entering and leaving." Please let the Respite Center Staff know if the chimes would present a problem for your family member.

_____ _____
(Signature of Consumer/Parent/ Legal Guardian) **(Date)**

The above authorizations are valid for one year from the signed date and must be signed by Guest, parent, or Legal Guardian. Please notify us <u>immediately</u> of any changes.

CC: CM/SC, FRCC, Nursing Staff, Respite File, Travel Packet 3/07

Attachment D (1 of 2)

STATE OF CONNECTICUT

DEPARTMENT OF DEVELOPMENTAL SERVICES

_____ **REGION**

DDS

PETER H. O'MEARA
COMMISSIONER

M. Jodi Rell
GOVERNOR

KATHERINE du PREE
DEPUTY COMMISSIONER

Name: _____ **Phone Number:** _____

Address: _____ **Date of Birth:** _____

Diagnosis: _____

_____

_____

Allergies: _____

_____

_____

Epi-Pen needed: Yes ☐ **No** ☐ **Sunscreen Allergy: Yes** ☐ **No** ☐

Diet: Regular Yes ☐ No ☐

Special Modifications/ Restrictions: _____

_____

Consistency: ***(Please Check One)***

- ☐ Whole (able to chew and swallow all forms of food without difficulty)
- ☐ **Cut-up (pieces of food ½" x ½" x ½ " roughly the size of a dime x ¼" high)**
- ☐ **Chopped (pea-sized, ¼" x ¼" x ¼")**
- ☐ **Ground (ground in a machine to size of small curd cottage cheese)**
- ☐ **Pureed (machine blended to a smooth consistency w/a pudding-like appearance)**

Liquid Consistency: ☐ **Thin (Regular)** ☐ **Nectar** ☐ **Honey** ☐ **Pudding**

Last Tetanus Vaccine: _____/_____/_____

Medical Limitations: _____

Transfer Instructions: _____

Order for Adaptive Equipment/OT/PT/other special Instructions i.e: (blood pressure, blood sugars, etc.)

_____

Check: Helmet ☐ AFO ☐ Wheelchair ☐ Ear Plugs ☐ Side Rails ☐ Other

The orders on this page are in effect for one year from the date signed unless changes have occurred.

Physician: _____ Phone Number: _____
Print Name

Address: _____ Fax number: _____

Physician's Signature: _____ Date: _____/_____/_____

Mail or fax form to: _____
Tel: _____ or **Fax:** _____

CC: CM/SC, FRCC, Nursing Staff, Respite File, Travel Packet (3/07)

STATE OF CONNECTICUT
DEPARTMENT OF DEVELOPMENTAL SERVICES
_____ REGION

DDS
PETER H. O'MEARA
COMMISSIONER

DDS Respite Center
Physician's Orders

Name: Phone Number:
Address: Date of Birth:
Diagnosis:
Allergies:

The above patient's family has requested respite services at DDS's respite center. The Connecticut State Laws and Regulations require a physician's written order for a nurse or non-licensed certified staff to administer any routine and/or over the counter medications. Please write out Physician's orders for: medications, diet changes, blood pressure and any other screenings, nebulizers, oxygen and treatments, etc. For all tube feedings, please include type and rate of infusion, pump or bolus, amount, type and times of flush.

Medication (Please print)	Dose	Route	Adm. Time	Reason Given

The above orders are in effect for 180 days unless otherwise specified. Behavior modifying Medications need to be renewed every 90 days. The RN may adjust medication times as needed.

Physician: _____ Phone: _____
Print name

Address: _____ Fax number: _____

Physician's signature: _____ Date: _____/_____/_____

Mail or fax form to: _____

Tel: _____ or **Fax:** _____

CC: CM/SC, FRCC, Nursing Staff, Respite File, Travel Packet (3/07)

Name: _____

DDS#: _____

Attachment E

DDS RESPITE CENTER PACKET
_____ REGION

RESPITE CENTER GUEST PERMISSIONS FORM

(Completed by Guest/family Member/Guardian prior to visit)

ALL authorizations are in effect for one year from the date of signature. Please notify us immediately of any changes.

1. AUTHORIZATION TO PARTICIPATE IN COMMUNITY ACTIVITIES

I do ☐ do not ☐ give permission for _____ to participate in community activities with the Respite Center Program.
First and last name

2. AUTHORIZATION FOR PHOTOGRAPHS AND PRESS

I do ☐ do not ☐ give permission for _____ to be photographed for DDS use.

I do ☐ do not ☐ give permission for _____ to be photographed for media use.

I do ☐ do not ☐ give permission for _____ to appear in media print.

3. AUTHORIZATION FOR AQUATIC ACTIVITIES

I do ☐ do not ☐ give permission for _____ to participate in boating and fishing activities.

I do ☐ do not ☐ give permission for _____ to participate in activities proximal to water*.

I do ☐ do not ☐ give permission for _____ to participate in swimming activities.

_____ _____
(Signature of Guest/Parent/Legal Guardian) **(Date)**

For boating, fishing, ice skating, water parks or activities proximal to water, as approved, the following are safe supervision levels for _____:
First and last name

Supervision levels:	**For boating/fishing**	**_____staff for _____guest(s)**	(not approved ☐)
	Proximal to water*	**_____staff for _____guest(s)**	(not approved ☐)
	Ice skating	**_____staff for _____guest(s)**	(not approved ☐)
	Water parks	**_____staff for _____guest(s)**	(not approved ☐)

_____ _____
(Signature of Guest/Parent/Legal Guardian) **(Date)**

*Proximal to water = picnics near water, feeding ducks, walks on the beach, etc….
** Hot tubs cannot be used without a physician's order.

☐ needs a lifejacket on at all times
☐ can stay in shallow water only
☐ no swimming skills
☐ limited swimming skills
☐ can swim in deep water with supervision
☐ independent swimmer trained in safe swim practices
☐ can swim independently without flotation devices
☐ requires one-to-one guest to staff ratio in water
☐ supervision needs will need to be evaluated by staff
☐ other:

Safe supervision level for swimming for _____is_____ staff_____ guest(s).
First and last name

_____ _____
(Signature of Guest/Parent/Legal Guardian) **(Date)**

CC: CM/SC, FRCC, Nursing Staff, Respite File, Travel Packet (3/07)

Name: _____

DDS#: _____

DDS RESPITE CENTER PACKET
Select Region REGION

LEISURE INTEREST SURVEY
(Completed by CM/SC or SDSW)

Name: _____ Date: _____ D.O.B: _____

Address: _____ Sex (check box): M ☐ F ☐

Phone: _____ DDS Case Manager: _____

1. List recreational activities which you currently participate in: _____

2. Indicate the recreational activities you prefer to participate in (check all that apply):
   - ☐ Music/Concerts
   - ☐ Aquatics
   - ☐ Exercise
   - ☐ Other: _____
   - ☐ Arts and Crafts Program
   - ☐ Spectator Sports
   - ☐ Organized team Sports
   - ☐ Social Events
   - ☐ Organized Games
   - ☐ Dining Out
   - ☐ Day trips
   - ☐ Dance

3. Identify short-term goals you would like to have addressed via recreational participation in activities (i.e. increase social involvement, increase physical activity, etc.): _____

4. Identify any medical/physical conditions which may affect participation in activities (i.e. asthma, seizure disorder, allergies, etc.): _____

5. Identify support/assistance needed to participate in recreational activities (i.e. staff assistance, adaptive equipment, etc.): _____

6. Identify issues, or concerns regarding community integration (i.e. fear of animals, transportation, limited attention span, Decreased safety awareness, loud noises, large groups, etc.): _____

7. Are you satisfied with your current level of participation in recreation and school activities?
   ☐ Yes ☐ No Explain: _____

8. Do you have money to pay for recreational activities? ☐ Yes ☐ No

9. Would you like to learn about Self-Advocacy? ☐ Yes ☐ No

Cc: FRC, Ind. File, Respite File Revised: 3/07

Name: _____

DDS#: _____

LEISURE INTERESTS

Check the activities that best describe your leisure interests. If you dislike or are not interested in an activity, Leave the space blank.

Music
- ☐ Listening to music
- ☐ Playing instruments
- ☐ Attending concerts
- ☐ Singing
- ☐ Other (specify): _____

Arts & Crafts
- ☐ Candlemaking
- ☐ Painting
- ☐ Woodworking
- ☐ Drawing
- ☐ Basketweaving
- ☐ Ceramics
- ☐ Latch hook
- ☐ Stenciling
- ☐ Other (specify): _____

Hobbies/Interests
- ☐ Attending church/temple
- ☐ Gardening/horticulture
- ☐ Cooking/baking
- ☐ Travel
- ☐ Photography
- ☐ Puzzles
- ☐ Shopping
- ☐ Computers
- ☐ Other (specify): _____

Social Activities
- ☐ Social Group
- ☐ Parties
- ☐ Dances
- ☐ Barbecues/picnics
- ☐ Fairs/festivals
- ☐ Parades
- ☐ Amusement Parks
- ☐ Dining out
- ☐ Other (specify): _____

Sports and Exercise
- ☐ Camping
- ☐ Dancing
- ☐ Aerobics
- ☐ Horseback riding
- ☐ Swimming
- ☐ Softball
- ☐ Basketball
- ☐ Bowling
- ☐ Soccer
- ☐ Tennis
- ☐ Jogging
- ☐ Miniature golf
- ☐ Hiking
- ☐ Fishing
- ☐ Bike riding
- ☐ Boating/canoeing
- ☐ Kite flying
- ☐ Sledding/tobogganing
- ☐ Roller/ice skating
- ☐ Frisbee
- ☐ Other (specify): _____

Entertainment
- ☐ Movies
- ☐ Plays
- ☐ Sporting events
- ☐ Museums
- ☐ Nature centers
- ☐ Arcades
- ☐ Other (specify): _____

Games
- ☐ Billiards
- ☐ Cards/Uno
- ☐ Checkers
- ☐ Bingo
- ☐ Table tennis
- ☐ Other (specify): _____

Name: _____

DDS#: _____

Attachment G

DDS RESPITE CENTER PACKET
_____ REGION
EVALUATION FOR BATHING AND PERSONAL CARE SAFETY SUPERVISION

Date Evaluation Completed: _____

Name: _____
DOB: _____
MR Level: _____
Guest Uses: ☐ **Bathtub** ☐ **Shower** ☐ **Whirlpool** ☐ **Other: _____**

Guest is at risk due to the following medical condition(s), physical disability and/ or behavioral issue(s):

_____
_____
_____
_____

SUPERVISION

☐ **No supervision required. Guest can bathe independently – no medical, physical or behavioral risks.**

☐ **Some supervision is required. Explain type of supervision needed and reason: _____**
_____
_____

☐ **Full, continuous supervision at all times while bathing. Explain type of supervision needed and reason:**
_____
_____
_____

Number of people needed to assist guest with bathing: 0 ☐ **1** ☐ **2** ☐ **3** ☐
Please describe need for assistance and / or bathing routine: _____

Guest Needs			Comments / Specifics
Ambulatory	yes	no	
Can call for assistance	yes	no	
Utilizes adaptive equipment (i.e. safety straps)	yes	no	
Complies with adaptive equipment	yes	no	
Uses special shampoo	yes	no	
Allergic to soaps	yes	no	
Uses lotions	yes	no	
Uses ear plugs	yes	no	
Enjoys bathing	yes	no	

Enter a prompt in the right hand column for each task using the key below

PROMPT LEVELS		TASK	PROMPT
I = Independent		Turns water on and off	
V = Verbal Prompt		Regulates water temperature	
P = Physical Prompt		Gets in and out of tub or shower	
M = Physical Manipulation		Washes Body	
U = Physically or cognitively unable to do		Shampoos hair	
R = Refuses to do		Dries body	

Information provided by: _____ Date: _____

Signature of Person completing form: _____ Date: _____

Name: _____

DDS#: _____

Attachment H

DDS RESPITE CENTER
_____ REGION
PRE-ADMISSION HEALTH CHECKLIST
(Completed by Nursing Staff, SDSW)

Guest Name:	**Address/Town:**	
Contact Person:	**Relation:**	**Home Phone: ( ) -**
Dates Approved For Respite: from / / AM/PM to		**/ / AM/PM**
Seizure Disorder: No ☐ Yes ☐	**If yes, type: _____**	**frequency: _____**
	Duration: _____	**Date of last seizure:**
Recent Illnesses/Injuries/Hospitalizations within the past year: _____		
Date Last Menses: / /	**Comments:**	
Concerns Discussed: _____		
Medic Alert Bracelet: (Type/Reason):		
Allergies/Reactions (medications, food, seasonal, other): _____		
Medications: Routine ☐ PRN ☐ None ☐	**Requested to bring in medication: Yes ☐ No ☐**	
How is medication administered?		
Is there a constipation problem? Yes ☐ No ☐		
If yes, please describe interventions:		
Medical/Adaptive equipment used? Yes ☐ No ☐	**Requested to bring in? Yes ☐ No ☐**	
If used, list all equipment:		
If summer, requested to bring in sunscreen? Yes ☐ No ☐		
Dietary Supplement required: Yes ☐ No ☐	**If yes, type:**	**Requested to bring in?**
G-Tube: Yes ☐ No ☐ Type:	**J-Tube: Yes ☐ No ☐ Type:**	**Type of infusion Pump:**
Type of Feeding:	**Requested to bring in?**	
Dietary restrictions:		
Is there a swallowing problem? Yes ☐ No ☐	**If yes, please explain:**	
Physician's Orders up-to-date? Yes ☐ No ☐	**DATE EXPIRED ___/___/___**	**Comments:**
Authorizations up-to-date: Yes ☐ No ☐	**DATE EXPIRED ___/___/___**	**Comments:**

Information was obtained via telephone on: DATE: ___/ ___/ ___ at _____ AM / PM

Signature of individual completing form: _____

CC: FRCC, Nursing Staff, Respite File 3/07

Name: _____

DDS#: _____

Attachment I

DDS RESPITE CENTER
_____ REGION

ADMISSIONS/ASSESSMENT

(Completed by SDSW/designee and/or Nursing Staff)

Name: Date: Time:

Person accompanying individual:

Day Phone: **( ) - -** Evening Phone: **( ) -** Relationship:

Address:

Name and of emergency contact person:

Address of emergency contact person:

Person, other than parent, authorized to discharge respite:

Appearance:

Adaptive Equipment:

Spending Money (List on personal spending sheet – attachment K): Yes ☐ No ☐ If yes amount: $

Staff admitting individual (Print):

Signature: **Date:**

Signature of person accompanying individual:

(Completed by RN, LPN, or Med. Certified Staff)

Medication (If labels do not match Physician's Orders individual may be Refused admission to Respite Center)	Amount brought in	Labels match Dr.'s orders

Body Check (Nurse or designee must be in attendance):
Physical Condition: Rash ☐ Congestion ☐ Cough ☐ Other: _____

Is there a constipation problem? Yes ☐ No ☐ If yes, date of last bowel movement: _____

Recent exposure to illness? Yes ☐ No ☐ If yes, please specify: _____

_____ _____
Signature of RN, LPN, or Med Certified Staff Completing above information **Date**

CC: FRC, Ind. File, Respite File Revised: 3/07

Name: _____

DDS#: _____

Attachment J

DDS RESPITE CENTER
_____ REGION

DISCHARGE ASSESSMENT

(Completed by Respite Center Site Nurse or Designee)

Adaptive/Special Equipment given to family? Yes ☐ No ☐
Body Check (Nurse , if available, must be in attendance):
Exposure to illness during the stay? Yes ☐ No ☐ If Yes, explain:
Is there a constipation problem? Yes ☐ No ☐ If yes, date of last bowel movement: _____
Were PRN medications administered during Respite stay? Yes ☐ No ☐ If Yes, parents must be notified and instructions Given for follow-up care. Instructions given to parents: _____

Medication	Amount taken home

Discharge Nurse: _____**Date:**_____ **Time:**_____

Staff discharging Individual: _____ **Date:** _____ **Time:** _____

Person receiving Individual: _____ **Date:** _____ **Time:** _____

Cc: FRC, Ind. File, Nursing Notes, Respite File Revised: 3/07

Name: _____

DDS#: _____

Attachment K

DDS RESPITE CENTER
_____ REGION

PERSONAL SPENDING SHEET

(Completed by SDSW or Designee)

Name: _____

	Beginning Balance		
Date	Items Purchased / Transaction	Amount Spent	Balance
	ENDING BALANCE		

Admission Staff Date Parent/Guardian Date

Discharge Staff Date Parent/Guardian Date

Attachment K

DDS RESPITE CENTER
_____ REGION

PERSONAL SPENDING SHEET

(Completed by SDSW or Designee)

Name: _____

	Beginning Balance		
Date	Items Purchased / Transaction	Amount Spent	Balance
	Ending Balance		

Admission Staff Date Parent/Guardian Date

Discharge Staff Date Parent/Guardian Date

CC: FRC, Ind. File, Respite File Revised: 3/07

OPTIONAL INFORMATION

Name: _____

DDS#: _____

Attachment L

DDS RESPITE CENTER
_____ REGION

GUEST SURVEY
(Completed by SDSW or Designee)

It is our hope that you enjoyed your experience with_____ Family Respite Center. The respite center Staff are dedicated to providing quality support, a comfortable environment, and fun for your family member during their respite stay. The following questions have been developed to help us better understand the needs and concerns of our visitors and families. Thank you in advance for taking the time to complete the questionnaire.

Questions for the individual/visitor

1. When you found out that you were coming to visit the center, were you looking forward to your visit? Yes ☐ No ☐
2. Did you feel comfortable with the staff? Yes ☐ No ☐
3. Did you feel comfortable with other visitors? Yes ☐ No ☐
4. Did you enjoy the food? Yes ☐ No ☐
5. Did you enjoy the activities? Yes ☐ No ☐
   Explain:
6. Did you like the room you slept in? Yes ☐ No ☐
   Explain:
7. Would you like to visit the center again? Yes ☐ No ☐
8. What would make your stay better?

Additional comments/suggestions (use back if necessary): _____

_____
_____
_____
_____
_____
_____
_____
_____
_____

CC: FRC, Ind. File, Respite File Revised: 3/07

Name: _____

DDS#: _____

Attachment M

DDS RESPITE CENTER
_____ REGION

RESPITE EVALUATION
(Completed by SDSW or Designee)

Name:	D.O.B:
Case Manager/ Service Coordinator:	Center Location:
Date of Arrival:	Time of Arrival:
Date of Departure:	Time of Departure:

Abilities and Skills
Describe the Skill Level and the Amount of Assistance Required

Eating/Drinking:	Self ☐	With Assistance ☐	Total Care ☐	Equipment Needed ☐
Dressing:	Self ☐	With Assistance ☐	Total Care ☐	Equipment Needed ☐
Toileting:	Self ☐	With Assistance ☐	Total Care ☐	Equipment Needed ☐
Bathing:	Self ☐	With Assistance ☐	Total Care ☐	Equipment Needed ☐
Grooming:	Self ☐	With Assistance ☐	Total Care ☐	Equipment Needed ☐

Communication: Verbal ☐ Non-Verbal ☐ Sign ☐ Language Board/Communication Device ☐
Hearing Impairment ☐ Hearing Aid ☐ Language Spoken:

Mobility: Independent ☐ Walker ☐ Wheelchair ☐ Other:

Visual Impairment: Glasses ☐ Blind ☐ None ☐

Sleeping Patterns: _____

Social Interactions: _____

Staff/Guest Interaction: _____

Guest Comments: _____

Behaviors Observed: _____

Comments: _____

Suggestions for Future Respite: _____

Completed By: _____ Date: _____
(SDSW/Designee)

Reviewed By: _____ Date: _____
(FS Respite Coordinator)

Reviewed By: _____ Date: _____
(Supervisor)

CC: FRC, Ind. File, Respite File Revised: 3/07

Name: _____

DDS#: _____

Attachment N

DDS RESPITE CENTER PERSONAL ITEMS INVENTORY

(Completed by SDSW or Designee. Copy kept in Respite File)

Individual:	**Admitting Staff:**	**Date:**
Date In:	**Parent Signature(Ad.):**	**Date:**
Specify number: Suit Cases ☐ Gym Bags ☐ Back Packs ☐	**Discharge Staff:**	**Date:**
Grooming Bag ☐ Handbag ☐ Wallet ☐	**Parent Signature(Dis.):**	**Date:**
Other:		**Date:**

Underwear

Quantity	In	Out
Underpants		
Undershirts		
Bras		
Socks		
Stockings		
Tights		
Diapers		
Attends		
Rubber pants		
Slips		

Enjoyment

Quantity	In	Out
Radio		
Cassette Player		
Tapes		
Videos		
Sec. Blanket		
Pillow		
Books		
Camera		
Toys		

Outerwear

Quantity	In	Out
Coat		
Jacket		
Hat		
Gloves		
Scarf		
Rain Gear		

Tops

Quantity	In	Out
Blouses		
Dresses		
Tank Tops		
T-Shirts		
Long sleeve		
Short sleeve		
Sweaters		
Sweatshirts		

Miscellaneous

Quantity	In	Out
Make up		
Pads		
Tampons		
Jewelry		

Bottoms

Quantity	In	Out
Shorts		
Skirts		
Jeans		
Cords		
Slacks		
One-piece outfits		
Bathing Suit		
Sweat Pants		

Footwear

Quantity	In	Out
Shoes		
Sandals		
Sneakers		
Boots		

Grooming

Quantity	In	Out
Comb		
Brush		
Pick		
Hair Accessories		
Shampoo		
Conditioner		
Tooth Brush		
Tooth Paste		
Shaving Cream		
Razor		
Electric Razor		
Lotions		
Powder		
Chap Stick		

Night Wear

Quantity	In	Out
Pajamas		
Bathrobe		
Slippers		
Slipper Socks		

Adaptive Equipment

	In	Out

Clothes Worn In

Name: _____

DDS#: _____

Attachment O

DDS RESPITE CENTER
_____ REGION
LEISURE ACTIVITIES
(Completed by SDSW or Designee)

Name: _____ Duration of Stay: _____

Preferred activities: 1. _____
2. _____
3. _____

COMMUNITY ACTIVITIES

Date	Activities Offered	Time	Reaction: 1-Dislikes 2-Indifferent 3-Enjoyed	Interacted with Community (check here)	Comments/Observations (i.e. was attentive, enjoyed activity or skill level, explain community interactions)	Staff Initials

Total activities offered: _____ Total time engaged in activities: _____

IN-HOUSE ACTIVITIES

Date	Activities Offered	Time	Reaction: 1-Dislikes 2-Indifferent 3-Enjoyed	Interacted with Community (check here)	Comments/Observations (i.e. was attentive, enjoyed activity or skill level, explain community interactions)	Staff Initials

Total activities offered: _____ Total time engaged in activities: _____ RTI or Designee Signature: _____

Cc: FRC, Ind. File, Respite File Revised: 3/07

DDS RESPITE CENTER
DDS _____ Region
PICA Prevention Guidelines for Respite Centers

PICA behavior is the ingestion of non-food, inedible objects, including liquids that are not Suitable for human consumption. PICA should be distinguished from "mouthing", which is sucking Or chewing on objects (fingers, toys, clothing) that cannot be swallowed because of size (definition Taken from S.C RPOG 2-M). PICA may be part of a compulsion to eat/drink non-food items or it May be due to the fact that the person cannot distinguish between food and non-food items because Their mental age is below three years.

This is a general guideline regarding interventions for PICA at the DDS respite centers. Information regarding supervision interventions and items the individual may ingest needs to be obtained from families/caregivers prior to admission. The environment in each setting needs to be considered, since different environments present a different set of circumstances. All attempts will be made to create a safe, supervised environment. As part of the respite packet, the **PICA Information Form** must be completed.

1. Prior to the individual with PICA entering the respite center, consideration needs to be given to securing cleaning supplies, shampoo, soap, and other items which have the potential to be ingested. Floors need to be vacuumed, swept, and mopped for cleanliness.

2. Clothes, furniture, and other items must be free of loose threads, pieces or other features that may be broken off, or removed and ingested.

3. The environment must be inspected on a regular basis several times per day to ensure there is no access to items the individual may ingest. All staff have a responsibility to routinely inspect the environment. If necessary, the staff person in charge may put into place an environment inspection form.

4. The staff must maintain visual supervision of the individual during awake hours. The staff person in charge may designate another staff member to do this and may rotate the responsibility. Visual supervision is to be provided – this must be clearly communicated to staff.

5. Staff needs to be vigilant in providing supervision when individuals are in vehicles Or away from the Respite Center. The vehicle needs to be checked prior to each use for wrappers, Rocks, etc. to eliminate the opportunity for the individual to find ingestible items since there is Potential for staff to be distracted from the individual(s) with PICA.

6. Prior to bedtime, bedrooms need to be checked for items on the floor, bed, dressers, table, etc. to ensure there are no such items which could be ingested. Please keep in mind how the roommates are assigned. Supervision checks need to be determined by the SDSW, or de-signer after discussion with the family/caregiver. If an individual attempts to ingest an item, staff need to intervene. Block and secure the item before it is ingested. Do not put your fingers in an individual's mouth to remove the item.

In the event an individual ingests an inedible item, the nurse will be contacted to determine the follow up treatment. In the event of obvious distress or for any chemical ingestion, 911 will be called and the guardian and on-call manager will be contacted.

Name: _____

DDS#: _____

DDS RESPITE CENTER
_____ Region

PICA Information for Respite Center Visits

THIS FORM IS VALID FOR ONE YEAR FROM THE DATE OF SIGNATURE.
PLEASE NOTIFY US IMMEDIATELY OF ANY CHANGES.

Name of Individual: _____ Date Form Completed: _____

1. Items the individual has ingested that are non-food:

_____
_____
_____

2. How often does this happen?:

_____
_____
_____

3. When was the last time that they ate or drank a non-food item, and what was the item?:

_____
_____
_____

4. How do you address this behavior in the home/school program/day program?:

_____
_____
_____

5. Do you have a specific written PICA guideline used at home/ school program/day Program? If yes, please provide a copy:

_____
_____
_____

6. Please list the level of supervision* when the individual is:

Awake : _____
Sleeping : _____
In bathroom: _____

***If family/caregiver stated the individual requires a 24 hour 1:1 within arms length, this situation will need to be reviewed at an administrative level.**

Comments: _____
_____
_____
_____

_____ _____
Signature of Legal Guardian/Parent **Date**

_____ _____
Signature of Staff **Date**

Cc: FRC, Ind. File, Respite File Revised: 3-07

Name: _____

DDS#: _____

RESPITE CENTER
SAFETY MANAGEMENT OVERSIGHT

The _____ Region Respite Centers provide families with an opportunity to have their family members stay in a safe, enjoyable and home-like environment through planned respite.

Purpose: To establish a standard safety oversight for admission to respite and activities available at the family Respite Centers.

Family Respite Center: Homes or residential units operated by DDS which provide planned, temporary supports to individuals who reside with their families, community training home providers or DCF foster families and who are eligible to receive services from DDS.

At the time of admission to a Family Respite Center the family/caregiver will be informed of the safety measures in place at the _____ Region Respite Center. Please review the following operations safety oversight identifiers:

- ❑ *Doors/Windows may be alarmed or secured.*
- ❑ *Installed outdoor fences and gates may be secured or locked, and doors/windows may be protected with safety knobs or locked to protect respite guest from readily accessing the following areas: outdoors, swim pool (if applicable), storage of chemicals, sharp knives, access to boiler rooms, medications, kitchen (cabinets, pantry or refrigerator), laundry room, basement and personal hygiene supplies*
- ❑ *Door chime mechanisms may be on the doors to alert staff of entry or egress to the Respite Centers.*
- ❑ *Physical/Psychological Management Techniques (if applicable to individuals with challenging behaviors)*
- ❑ *Dietary Restriction (e.g. peanut butter): If someone has a food allergy, you may be requested to not bring that item into the respite center.*

While we strive to maintain the least restrictive environment at all times, the needs of our respite guests vary, so that some or all of these measures may be in place at the time of your family member's respite stay. This is to ensure the safety of all of our respite guests. Every effort will be made to ensure that only the restrictive measures required to maintain the health and safety of all our guests during a particular weekend are being used.

Your signature will confirm review and consent to these identified safety measures.

_____	_____	_____	_____
Individual's Signature	*Date*	*Parent/Guardian Signature (or designee)*	*Date*

Revised 5/2008

Name: _____

DDS#: _____

DDS Respite Center

Conditions for Respite Center Stay

Please sign below if you agree to the following terms and the_____ Region Respite Center requirements:

- ❑ *All necessary paperwork is complete and submitted one month prior to admission*
- ❑ *All emotional and physical health information is accurate and current*
- ❑ *Medication bottles correspond to Physician's orders*
- ❑ *Guest is in good emotional and physical health and free from infectious diseases for two weeks prior to admission*
- ❑ *Parent or guardian must be present upon admission and discharge to review medications and health status with nursing staff*
- ❑ *Respite center staff must receive training in any adaptive equipment, medical devices or behavior support plans*

If any of these requirements are not met, Respite may be denied until all requirements are met.

_____	_____	_____	_____
Individual's Signature	*Date*	*Parent/Guardian Signature (or designee)*	*Date*

Additional Reviews:

Review Date	Signature	Review Date	Signature

Revised 5/2008

Name: _____

DDS#: _____

DDS Respite Center Letter of Understanding

Attending School/Day Program

I, _____, hereby give permission for my son/daughter, _____, to attend school/day program while scheduled to stay at the DDS Respite Center.

I understand that the DDS Respite Center staff are not responsible for my son/daughter, _____,during the time they attend school/day program.

The school/day program is responsible for transporting my son/ daughter to and from school/day program. I will coordinate this with the DDS Respite SDSW and the designated person at school/day program to make sure transportation is arranged.

_____ _____

Parent/Legal Guardian (or designee) *Date*

Revised 5/2008

EMERGENCY EVACUATION SUMMARY

Guest Name: _____

☐ 1 - **Total Assistance** – Guest may be unable to ambulate, may use a wheelchair, or may exhibit a behavioral response that warrants this level of assistance.

☐ 2 - **Physical Assistance** – Guest may have an unsteady gait, guest may have a visual or hearing impairment, or may otherwise need assistance ambulating.

☐ 3 - **Verbal Assistance** - Verbal Prompt needed

☐ 4 - **Independent** - Able to respond to alarm and/or emergency

Comments: _____

**Evacuation routes and meeting places will be reviewed during each stay.

Parent/Guardian Signature: _____ Date: _____/_____/_____

Staff Signature : _____

Additional reviews:

Review Date	Signature	Review Date	Signature

Revised 5/2008