McGuire Memorial - Pre-Admission Application

Today's Date: _____

Consumer's Name: _____
Last First Middle

Current Address: _____
House/Street

_____
City State Zip Code

Home Phone: _____ County of Residence: _____

Sex: _____ Date of Birth: _____ Current Age: _____

Social Security Number: _____

Race: _____ Religion: _____

School District of Residence: _____

Height: _____ Weight: _____ Hair Color: _____ Eye color: _____

Medical Diagnosis: _____

_____

_____

_____

Supports Coordination Unit: _____

Support Coordinator: _____ Phone Number: _____

Name of Person making referral: _____

Relationship: _____ Phone Number: _____

Inspiring Hope | Fostering Growth

Pre-Admission Application Continued:

Consumer's Name: _____

FAMILY INFORMATION:

Parents:

Father's Name: _____ Mother's Name: _____

Address: _____ Address: _____

County: _____ County: _____

Telephone: Home: _____ Telephone: Home: _____

Work _____ Work: _____

Cell: _____ Cell: _____

Birthdate: _____ Age: _____ Birthdate: _____ Age: _____

Social Security #: _____ Social Security #: _____

Email: _____ Email: _____

Religion: _____ Religion: _____

Employer: _____ Employer: _____

Education: _____ Education: _____

Occupation: _____ Occupation: _____

Marital Status: ____ Married ___ Single ____ Divorced ___ Widow

Marital Status: ___ Married ___ Single ___ Divorced ___ Widow

Does the consumer have a court appointed legal guardian? _____ Yes _____ No

Name of Legal Guardian: _____

Address of Legal Guardian: (if different from parents):

_____

House/Street

_____

City State Zip Code

Phone Number: _____ Cell Phone: _____

Work Phone: _____ Email: _____

Pre-Admission Application Continued:

Consumer's Name: _____

Siblings:

Name:				
Sex:				
Birthdate:				

REFERRAL INFORMATION

Current living arrangements, supports, services received: _____

_____

_____

_____

Do you have a waiver through your county: _____ Yes _____ No

Type of Waiver: _____

Do you have a current ISP: _____ Yes _____ No Date of ISP: _____

Has the county completed a PUNS forms for you? _____ Yes _____ No

Current PUNS Status _____

If consumer does not live with family, please supply the following information:

Name of caretaker/residential agency: _____

Address: _____

House/Street

_____

City State Zip Code

Contact Person: _____ Phone Number: _____

How did you hear of McGuire Memorial? _____

_____

_____

Pre-Admission Application Continued:

Consumer's Name: _____

Why are and what type of services are being requested? _____

_____

_____

Which programs are you seeking interested in? Please check all that apply

_____ Main campus residential (ICF/ID)
_____ Employment Option Center
_____ Respite program
_____ Other

_____ Community Homes
_____ Main Campus ATF Program
_____ Day School

MEDICAL INFORMATION

Does this consumer have a diagnosis of?

_____ Intellectual Disability
_____ Mild _____ Moderate ____ Severe
_____ Autism
_____ PDD
_____ Other (Please specify)

_____

_____

_____

Age when disability was identified _____

What is believed to be cause of disability?

_____ Genetic _____ Illness
_____ Birth Trauma _____ Accident
_____ Unknown

Date of Last Complete Physical:

_____

Physicians: (please list all physicians including dentists)

Name: _____
Specialty: _____
Address: _____

_____
Phone: _____
Date of last exam: _____

Name: _____
Specialty: _____
Address: _____

_____
Phone: _____
Date of last exam: _____

Name: _____
Specialty: _____
Address: _____

_____
Phone: _____
Date of last exam: _____

Name: _____
Specialty: _____
Address: _____

_____
Phone: _____
Date of last exam: _____

Pre-Admission Application Continued:

Consumer's Name: _____

Does this consumer take any prescribed medications? _____ Yes _____ No

If yes, please list all current medications

Medication	Dosage	Frequency	Reason	Date begun

Does the consumer have any hearing Problems? _____ Yes _____ No
Please check all that apply.

_____ No Problems Noted
_____ Deaf
_____ Hearing Loss ____ Both Ears ____ One Ear ____ Mild ____ Moderate ____ Severe
_____ Hearing Aids _____ Should use hearing aids but refuses
_____ Other _____

Please describe and specify any hearing concerns checked.

_____
_____
_____

Does the consumer have any visual problems? _____ Yes _____ No
Please check all that apply.

_____ No Problems Noted
_____ Near Sighted
_____ Far Sighted
_____ Astigmatism
_____ Glaucoma
_____ Cataracts
_____ Blind
_____ Legal Blindness _____ Both Eyes _____ One Eye
_____ Wears Glasses _____ Should wear glasses but refuses
_____ Other _____

Pre-Admission Application Continued:

Consumer's Name: _____

Please describe and specify any vision concerns checked.

_____

_____

_____

Are immunizations current/up to date? _____ Yes _____ No

Date/ type of last immunization: _____

Has consumer had a Mantoux TB test in the last 2 years _____ Yes _____ No

Results of TB test: _____ Date of Test: _____

Has consumer previously had surgery? _____ Yes _____ No

If yes, please list date and reasons for surgery

Surgery Reason Date

_____

_____

_____

_____

_____

Has consumer ever been hospitalized for reason other than surgery? ____ yes ____ no

Date of hospitalization Reason

_____

_____

_____

_____

_____

_____

Has the consumer ever had seizures? _____ Yes _____ No

If yes, please describe type of seizures and treatment:

_____

_____

_____

_____

Pre-Admission Application Continued:

Consumer's Name: _____

Does consumer currently have seizures? _____ Yes _____ No

If yes, please describe current type of seizures and treatment: _____

_____

_____

_____

_____

_____

Date of last recorded seizure: _____

Does the consumer have any known allergies? _____ Yes _____ No

If yes, please specify allergy (environmental, medication, food, other), reaction and current treatment: _____

_____

_____

_____

_____

Is the consumer covered by medical insurance? _____ Yes _____ No

Please list name of all coverage, holder of policy, current policy number: _____

_____

_____

_____

_____

Current nutritional needs:

Diet: _____

How food prepared is: _____ Cut up in small pieces _____ Chopped _____ Puree

Favorite Foods: _____

Foods refused: _____

Liquids: (describe how taken) _____

Pre-Admission Application Continued:

Consumer's Name: _____

Describe any feeding problems, concerns and current treatment: _____

_____

_____

_____

_____

_____

Behavior Concerns

_____ Please check any that apply:

_____ Self Injurious Behaviors
_____ Tantrums
_____ Physical Aggression (others)
_____ Hyperactive
_____ Property destruction
_____ Ritualistic
_____ Jeopardizes Personal Safety
_____ Self Stimulatory (rocking, etc)
_____ Elope/Runs Away
_____ Depressive
_____ Suicidal
_____ Oppositional Defiance
_____ Does not relate to peers
_____ Other (specify)

_____

Explain any items checked in detail to describe the behavior and when occurs:

_____

_____

_____

_____

_____

_____

Has consumer been treated or currently being treated by a psychiatrist? ___ Yes ___ No

If yes, please provide name of psychiatrist, list diagnosis and current treatment.

Physician: _____

Address: _____

_____

Phone Number: _____

Diagnosis: Treatment/Medication

_____

_____

_____

_____

_____

Pre-Admission Application Continued:

Consumer's Name:_____

Has consumer every required inpatient hospitalization for behavior/psychiatric concerns?
_____ Yes _____ No

If yes, please list date/ reason/location of treatment:

Date	Reason	Location of treatment

Does the consumer had/have any sleep difficulties? _____ Yes _____ No

If yes, please specify.

_____
_____
_____
_____
_____

Developmental

Communication Skills:

Expressive

_____ Uses complete sentences
_____ Speaks in phrases only
_____ No expressive communication
_____ Speaks in single words only
_____ Uses gestures and sounds
_____ Uses sign language
_____ Uses augmentative device (specify)
_____
_____
_____ Uses pictures
_____ Other (specify)
_____

Receptive

_____ Knows name when called
_____ Understands simple conversation
_____ Understands conversation
_____ Respond to simple commands
_____ Recognizes familiar people/family
_____ Identifies some common objects
_____ Responds appropriately to humor
_____ No responses

Pre-Admission Application Continued:

Consumer's Name:_____

Activities of Daily Living

Please indicate one of following levels of assistance required for each task

1- No Assistance Needed; 2 - Some Assistance; 3 - Much Assistance; 4 - Complete Assistance

_____ Bathing
_____ Dressing
_____ Undressing
_____ Eating
_____ Toothbrush/oral hygiene
_____ Hair grooming
_____ Toileting

Is the consumer continent of bowel and bladder? Daytime: _____ Yes _____ No
Nighttime: _____ Yes _____ No

Does the consumer use ATTENDS diapers? _____ Yes _____ No

Please indicate if the consumer can perform the following:

Hold head erect	_____ Yes _____ No	Assists with transfer's	_____ Yes _____ No
Sit independently	_____ Yes _____ No	Crawls/scoots	_____ Yes _____ No
Rolls	_____ Yes _____ No	Stands alone	_____ Yes _____ No
Walks	_____ Yes _____ No		

Please list any adaptive equipment/braces used:

_____
_____
_____
_____
_____

Does the consumer use a wheelchair? _____ Yes _____ No

When was wheelchair purchased? _____ Vendor Used _____

Education History

Home School District of Family _____

Is the consumer currently of school age? ___ Yes ___ No / Graduated ___ Yes ___ No

What school does the consumer currently attend?

_____

Pre-Admission Application Continued:

Consumer's Name: _____

Type of Class: _____ Date of most recent IEP: _____

Name/type of school attended	Dates attended	Reason for leaving

Individual Profile

Strengths (please list strengths)	Needs (please list needs)

Interests/likes (please list)	Dislikes (please list)

Personal Goals of Consumer: _____

Family/Guardians Goals for Consumer: _____

Pre-Admission Application Continued:

Consumer's Name: _____

Describe a typical day for consumer (include morning, afternoon and evening):

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Reason for seeking services from McGuire Memorial: _____
_____
_____
_____
_____
_____
_____

How soon are you in need of the desired service? _____
_____
_____
_____
_____

_____
Signature/date of Informant/Family/Guardian

_____
Signature/date of Supports Coordinator

_____
Signature of Individual Seeking Services/Date (If applicable)

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