Ray Graham Association®
Empowering people with disabilities to reach, grow, and achieve.™

Illinois Council on Developmental Disabilities

Date:

PATIENT INFORMATION		**CONTACT INFORMATION**
Preferred Name:		Legally Responsible Name:
	Date of Birth:	Relationship of Legally Responsible:
	Sex at Birth: Other	Day Phone of Legally Responsible:
	Current Gender: Other	Night Phone of Legally Responsible:
	Race: Other	Email of Legally Responsible:
	Height:	Address of Legally Responsible:
	Weight:	
	Religion:	
Address:		Additional Contact Name:
		HOUSING
Patient Phone:		Housing Status: Lives Alone
Patient Email:		Residential Service Provider:
Primary Physician:		Monday-Friday Day Hours:
Primary Physician Phone:		Day Contact Name:
Specialist Physician Name:		Day Contact Phone:
Specialist Physician Phone:		Evening Contact Name:
Specialist Physician Specialty:		Evening Contact Phone:

RISKS			**DNR:**	On File At:
☐Implants	☐Pacemaker	☐Falls	**ORIENTATION:**	☐To Person (knows their name)
☐Feeding Tube	☐Aspiration	☐Seizures		☐To Place (knows where they are)
☐Bedsores	☐VNS			☐To Time (knows current day/time)
☐Other:			**OXYGEN USE:**	Type: Amount:
CURRENT MEDICATIONS: List Attached			**ALLERGIES:**	List Attached

BRIEF MEDICAL

☐Dentures/Dental	☐Seizures	☐Thyroid Disease	☐Other:
☐Mental Illness	☐Cerebral Palsy	☐CPAP	
☐Diabetes	☐Genital Urinary	☐Oxygen	
☐ UTI (Urinary Tract Infection)			

PAIN SIGNS	☐ SBI (Self-Injury Behavior)	☐Crying	☐Flinching	☐Other:	
	☐Fetal Position	☐Grimacing	☐Screaming		
FEAR SIGNS	☐Physical Agitation	☐Crying	☐Flinching	☐Non-Responsive	☐Other:
	☐Still	☐Grimacing	☐Screaming	☐Rapid Breathing	
ANXIETY TRIGGERS	☐Loud Noises	☐Touching	☐Masks	☐Men	☐Other:
	☐Crowds	☐Needles	☐Procedures	☐Women	
CALMING TECHNIQUES	☐Music	☐Light	☐Books	☐Explain Service	☐Other:
	☐Touch	☐Dim Light	☐Massage	☐Soft Speech	

COMMUNICATION	Primary Language:	☐Understands	☐Speaks
	Secondary Language:	☐Understands	☐Speaks
	☐Needs Translator ☐Sign Language ☐Nonverbal Sounds		
	☐Communication Devices ☐Needs Time to Respond ☐Other		
VISION	Blind	HEARING	Deaf
MOBILITY	☐Independent ☐Cane ☐Wheel Chair ☐Assistive Devices		
	☐Requires Minimum Assist ☐Requires Total Assist		
	☐Other:		

Date:

ACTIVITIES OF DAILY DRESSING AND LIVING			
TOILETING		Dressing	Complete Assist
□Incontinent to Bowel	□Urinal	Bathing	Complete Assist
□Incontinent to Bladder	□Commode	Oral Care	Complete Assist
□Needs Bathroom Assist	□Diapers	Peri-Care	Complete Assist
□Bedpan		Hair Care	Complete Assist
□Other:		Handedness	Right Handed
		Eating	Complete Assist
		Drinking	Complete Assist

DIET & NUTRITION	RESTRICTED FOODS	FAVORITE FOODS/DRINKS
□Regular		
□Soft		
□Puree		
□Chopped		
□Mechanical		
□History of Aspiration		
□Feeding Tube		
□Other:		

CURRENT DAY PROGRAM	FAVORITE ACTIVITIES

INSURANCE INFORMATION		ICD-10 INFORMATION
SSN:		**Intellectual Disability Diagnosis:**
Medicare:	**Medicare Number:**	
Medicaid:	**Medicaid Number:**	
Primary Insurance:		
Primary Policy Number:		**Mental Health Diagnosis:**
Primary Policy Holder Name:		
Secondary Insurance:		
Secondary Insurance Number:		
Secondary Policy Holder Name:		**Other Diagnosis**
Prescription Coverage:		
Other:		

ADDITIONAL INFORMATION

Health Resume For: **Date:**

FREQUENCY	MEDICATION	FORM (TABLET, LIQUID,ETC)	DOSAGE

KNOWN ALLERGIES

OTHER INFORMATION

PREPARED BY: