FORM # 645 (B).1 Admission Packet/Screening

Individual Name: _____ Unique ID#:_____

Clark Quality Care

DATE OF INITIAL CONTACT _____

NAME/TITLE OF PERSON COMPLETING FORM _____

PRIMARY DIAGNOSIS _____ SECONDARY DIAGNOSIS _____

PLEASE CHECK APPROPRIATE SERVICE

WAIVER SERVICE	NON-WAIVER SERVICE (PRIVATE PAY)
• COMMUNITY RESIDENTIAL WAIVER SERVICES	• PRIVATE PAY

INDIVIDUAL'S FULL NAME _____

TYPE OF CURRENT RESIDENCE _____

ADDRESS _____

_____

HOME PHONE _____ WORK PHONE _____

MEDICAID # _____

MEDICARE # _____ OTHER INSURANCE _____

DOB _____ AGE _____

GENDER: • MALE • FEMALE

MARITAL STATUS: • SINGLE • MARRIED • SEPARATED • DIVORCED • WIDOWED

CSB/BHS _____ CSB/BHS PROVIDER # _____

CASE MANAGER _____

SERVICE REQUESTED: _____

REASON FOR REQUESTED
SERVICE:_____

_____

_____

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Individual Name: _____ Unique ID#:_____

AGENCY USE ONLY

• ACCEPTED FOR ADMISSION	• ADMISSION DENIED
DATE OF ADMISSION: _____ DATE SERVICES INITIATED: _____	EXPLANATION: _____ _____
• REFERRAL TO OTHER SERVICES	• WAIT LIST/ADMISSION PENDING
DATE OF REFERRAL: _____ REFERRAL TO: _____ _____	DATE: _____ #ON WAITLIST: _____ SERVICE AWAITING: _____

FAMILY INFORMATION

• PARENT • LEGAL GUARDIAN • OTHER _____

Name _____ Address _____ _____	Relationship _____ Home Phone_____ Work Phone _____
Name _____ Address _____ _____	Relationship _____ Home Phone_____ Work Phone _____

EMERGENCY CONTACT

Name _____ Address _____ _____	Relationship _____ Home Phone_____ Work Phone _____

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Individual Name: _____ Unique ID#:_____

GENERAL INDIVIDUAL INFORMATION

MOST PROMINENT MEANS OF COMMUNICATION _____

ACTIVITIES/ITEMS OF INTEREST (PRIMARY, SOCIAL, ACTIVITY, TACTILE, TOKEN)

_____

_____

_____

DISLIKES: _____

_____

_____

BEHAVIORS:
DESCRIBE ANY INAPPROPRIATE BEHAVIORS AND CONSEQUENCES. INCLUDE SIGNIFICANT EVENTS PRIOR TO THE BEHAVIOR.

_____

_____

_____

WHAT GOALS OR OUTCOMES ARE YOU SEEKING FROM THE PROGRAM?

_____

_____

_____

MEDICAL INFORMATION

MEDICATION	DOSAGE	TIMES	PURPOSE

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Individual Name: _____ Unique ID#:_____

Special Instructions for Medication Administration

_____

_____

History of Seizures? • YES • NO If yes, please describe

_____

_____

_____

Special Diet? • YES • NO If yes, please describe

_____

_____

Allergies? • YES • NO If yes, please describe

_____

_____

Date of Last TB Test _____ Results _____

Date of Last Physical _____ Completed by: _____

Other Medical Conditions?

_____

_____

_____

Physician's Name _____

Address _____

Phone Number _____

LEGAL

OWN LEGAL GUARDIAN • YES • NO

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Individual Name: _____ Unique ID#:_____

IF NO, NAME, ADDRESS, AND PHONE NUMBER OF LEGAL GUARDIAN

_____

_____

- ADJUDICATED INCOMPETENT? Date _____ Court _____
- WILL? LOCATION _____
- OTHER _____

_____ _____
Person Making Referral Signature Date

_____ _____
Program Director/QDDP Signature Date