Location:_____ Form #157R – 02/15

Case #:_____

The Center

RESIDENTIAL INTAKE CHECKLIST

Name: _____ Date of Birth _____

All documents should be submitted to Records Management within 5 working days <u>prior</u> to the entry date.

PRE – ADMISSION DOCUMENTATION REQUIREMENTS

Documents Required Before Starting

_____ Application for Services #145
_____ Copy of Letter of Guardianship and Verification of annual renewal (if applicable)
_____ DMR – Determination of Mental Retardation **or**
_____ Psychological Evaluation *(less than 10 yrs old*)
_____ ICAP *(less than 1 yr old)*
_____ Physical Examination #04 *(less than 1 yr old)*
_____ Dental Evaluation #11
_____ Hearing Screening #09
_____ Vision Screening #10
_____ Admissions Medication History #18
_____ Physician's Orders #08 (if applicable)
_____ Self Administration of Medication #80
_____ Copy of TB Test *(less than 1 year old)* #76
_____ Copy of DPT/td *(less than 10 yrs old)* #120
_____ Seizure Classification #165 (if applicable)

Additional Documents – if available

_____ Copy of Birth Certificate
_____ Copy of Texas Identification Card
_____ Copy of Social Security Card
_____ Copy of Medicaid Card
_____ Copy of Medicare Card
_____ Copy of HMO/PPO/Other Insurance Card
_____ Copy of SSI Award Letter

MOVE IN DOCUMENTATION REQUIREMENTS

Initial Support Plan Packet to include the following documents:

_____ Initial Residential Services and Supports Plan #12
_____ Admission Funding Data #151
_____ Agreement for Residential Services #02
_____ Financial Authorization Form #59
_____ Notice of Personal Funds-Personal #204 *(ICF only)*
_____ Notice of Personal Funds-Provider #205 *(ICF only)*
_____ Emergency Authorization #41
_____ Advanced Directives #45
_____ Medication Policy #06
_____ Physician's Orders for Self Administration of Meds #80
_____ Residential Rules #101
_____ Resident's Rights #127
_____ Rights Acknowledgment #111
_____ Program Information Receipt #113
_____ Notice of Privacy Practices #110
_____ 24 Hour Activity Schedule #128 *(ICF only)*
_____ Residential Training Objective #25
_____ Residential Service Objective #38
_____ Full Body / Head & Chest Photos

30 DAY ASSESSMENT DOCUMENTATION REQUIREMENTS

_____ 30 Day Assessment Interim Staffing #102
_____ Training Objective #25 *(if applicable)*
_____ Service Objective Frequency Chart #38 *(if applicable)*
_____ Intermediate Care Facility Assessment #62 *(ICF only)*
_____ Residential Personal Skills Profile #160
_____ Inventory of Belongings (Female) #162
_____ Inventory of Belongings (Male) #163
_____ Nutritional Evaluation #27 or #42
_____ Comprehensive Nursing Assessment #8584

OTHER DOCUMENTS RECEIVED

_____Other_____
_____Other_____
_____Other_____
_____Other_____

THE CENTER

APPLICATION FOR SERVICES / ENROLLMENT FORM

GENERAL INFORMATION

DATE OF APPLICATION: _____

NAME OF APPLICANT: _____
Last Name First Name Middle Initial

PRESENT ADDRESS: Street Address: _____

City: _____ State: _____ Zip: _____

PHONE NUMBER: [Home] (____)_____ [Emergency] (____)_____

EMERGENCY CONTACT: _____ **RELATIONSHIP:** _____

DATE OF BIRTH: _____ **AGE:** _____ **S/S #**_____ **SEX**: ☐ Male ☐ Female

MARITAL STATUS: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

PRIMARY LANGUAGE: ☐ English ☐ Spanish ☐ Other, specify: _____

COMMUNICATION MODE: ☐ Verbal ☐ Gestures ☐ Vocalizations ☐ Sign Language

COMMUNICATION DEVICE(S): _____ **RELIGION:** _____

HAIR: _____**EYE:** _____**HEIGHT:** _____**WEIGHT:** _____**ETHNICITY:** _____

CLIENT OR GUARDIAN _____ **DATE:** _____
Signature

FOR OFFICE USE ONLY

PROGRAMS APPLYING FOR

☐ AAC - West Dallas
☐ ATES – Day Habilitation
☐ ATES - Vocational
☐ ATES – Young At Heart
☐ Cullen - Assisted Living Room # _____
☐ Cullen - Independent Living Room #_____
☐ Willow River Farm House # _____
☐ WRF-Assisted Living House # _____
☐ WRF-Day Program
☐ HCS Foster Companion Care
☐ HCS Supervised Home Lvg
☐ HCS Residential Supervised
☐ HCS Supported Living

FUNDING

☐ Private Pay ☐ TXHML ☐ ICF/MR ☐ The Center HCS

☐ Medicaid MCO ☐ Contract ☐ Other HCS: _____

DATE FUNDING VERIFIED by ADMISSIONS COORDINATOR: _____

ADMISSION DECISION Date Applicant Informed of Decision: _____

☐ Approved ☐ Approved - Waiting List ☐ Not Approved

Enter Date: _____ Entered on List: _____ Reason: _____

Assigned Program Coordinator: _____

_____ _____ _____
Signature of Social Worker Signature of Dept. Director/Manager Signature of Chief Operating Officer

THE CENTER
APPLICATION FOR SERVICES / ENROLLMENT FORM

NAME:_____ **DOB:** _____ **DATE:** _____

FAMILY/CONTACTS

NAME OF FATHER: _____

Describe Contact: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: [Home] (____)_____ [Work] (____)_____

Phone: [Cell] (____)_____ **Email Address:** _____

NAME OF MOTHER: _____

Describe Contact: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: [Home] (____)_____ [Other/Emergency] (____)_____

Phone: [Cell] (____)_____ **Email Address:** _____

NAME OF EMERGENCY CONTACT: _____

Relationship to Applicant: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: [Home] (____)_____ [Other/Emergency] (____)_____

Phone: [Cell] (____)_____ **Email Address:** _____

NAME OF EMERGENCY CONTACT: _____

Relationship to Applicant: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: [Home] (____)_____ [Other/Emergency] (____)_____

Phone: [Cell] (____)_____ **Email Address:** _____

THE CENTER
APPLICATION FOR SERVICES / ENROLLMENT FORM

NAME:_____ **DOB:** _____ **DATE:** _____

BACKGROUND

PLACE OF BIRTH: City: _____ County: _____ State: _____

US CITIZENSHIP ☐ Yes ☐ No **LEGAL STATUS** ☐ Competent ☐ Incapacitated

if has a court appointed Guardian:
Name of Guardian: _____

Relationship to Applicant: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: [Home] (____)_____ [Other/Emergency] (____)_____

Date Appointed by Court: _____ Court Case Number: _____

County: _____ State: _____

INSURANCE

MEDICAID
☐ Yes, Number (#): _____
☐ No, have applied and been denied
☐ No, have never applied

MEDICARE
☐ Yes, Number (#): _____
☐ No, have applied and been denied
☐ No, have never applied

HMO/PPO ☐ Yes, Policy Number (#): _____
Company Name: _____
☐ No

LIFE INSURANCE (needed only if applying for a residential program) ☐ Yes, Policy Number (#): _____
Company Name: _____
☐ No

BURIAL INSURANCE (needed only if applying for a residential program) ☐ Yes, Policy Number (#): _____
Company Name: _____
☐ No

INCOME

ESTIMATED ANNUAL INCOME OF APPLICANT: _____

PRIMARY SOURCE OF INCOME: ***(check one)***
☐ SSI ☐ Wages ☐ Other, specify: _____

OTHER MEANS OF FINANCIAL SUPPORT: _____

DESCRIBE APPLICANT'S PARTICIPATION IN COMMUNITY/NEIGHBORHOOD:

THE CENTER
APPLICATION FOR SERVICES / ENROLLMENT FORM

NAME:_____ **DOB:** _____ **DATE:** _____

MOBILITY/SELF CARE

Mobility ***(check one)***

☐ Walks Independently ☐ Walks with Assistance from Others
☐ Uses Wheelchair Independently ☐ Uses Wheelchair with Assistance from Others

Describe/List Any Adaptive Equipment Used for Mobility: _____

Describe Assistance Needed to Get from One Place to Another: _____

Eats Meals Independently ☐ Yes ☐ No, please describe help needed: _____

Bathes Independently ☐ Yes ☐ No, please describe help needed: _____

Dresses Independently ☐ Yes ☐ No, please describe help needed: _____

THE CENTER
APPLICATION FOR SERVICES / ENROLLMENT FORM

NAME:_____ **DOB:** _____ **DATE:** _____

Uses Rest Room Independently ☐ Yes ☐ No, please describe help needed: _____

_____

_____

Describe Any Other Assistance Needed/Comments: _____

_____

_____

_____

_____

_____

MEDICAL/HEALTH CARE

PRIMARY PHYSICIAN: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: [Office] (____)_____ [Fax] (____)_____

KNOWN ALLERGIES ***(food, medication, other)***: _____

_____

EXISTING MEDICAL CONDITIONS/DIAGNOSES: _____

_____

_____

SEIZURES ☐ No ☐ Yes, please explain: _____

_____

_____

HEARING IMPAIRMENT ☐ No ☐ Yes, please explain: _____

_____

_____

THE CENTER
APPLICATION FOR SERVICES / ENROLLMENT FORM

NAME:_____ **DOB:** _____ **DATE:** _____

VISION IMPAIRMENT ☐ No ☐ Yes, please explain: _____

_____

_____

ADAPTIVE EQUIPMENT/POSITIONING ☐ No ☐ Yes, please explain: _____

_____

_____

_____

TAKES MEDICATIONS INDEPENDENTLY ☐ Yes ☐ No, please explain: _____

_____

_____

MEDICAL/HEALTH CARE

CURRENT MEDICATIONS

Medication	Date Prescribed	Reason for Use

MEDICAL HISTORY **please list/describe hospitalizations and significant illnesses**

Date	List or Describe Hospitalization or Surgery or Illness

THE CENTER
APPLICATION FOR SERVICES / ENROLLMENT FORM

NAME:_____ **DOB:** _____ **DATE:** _____

ADDITIONAL COMMENTS RELATED TO MEDICAL/HEALTH CARE: _____

FOR OFFICE USE ONLY

Advance Directive ☐ No ☐ Yes (attach copy) DNR Order ☐ No ☐ Yes (attach copy)

INTERACTIONS

DESCRIBE HOW APPLICANT INTERACTS WITH OTHERS: _____

DESCRIBE BEST WAY TO INTERACT WITH THE APPLICANT: _____

DESCRIBE THINGS THAT THE APPLICANT LIKES OR THAT MOTIVATE HIM/HER:

THE CENTER
APPLICATION FOR SERVICES / ENROLLMENT FORM

NAME:_____ **DOB:** _____ **DATE:** _____

DESCRIBE APPLICANT'S ABILITY TO MAKE CHOICES: _____

_____

_____

_____

DESCRIBE ANY SIGNIFICANT BEHAVIORS: _____

_____

_____

_____

_____

EDUCATION/SERVICES/EMPLOYMENT

EDUCATION (schools attended)

Name of School	City	State	Dates Attended From/To	Highest Grade Completed

CURRENT SERVICES ***(includes residential, vocational, job training, in-home care)***

Date Services Began	Type of Service(s)	Agency Providing the Service(s)	City	State

THE CENTER
APPLICATION FOR SERVICES / ENROLLMENT FORM

NAME:_____ **DOB:** _____ **DATE:** _____

PREVIOUS SERVICES ***(includes residential, vocational, job training, in-home care)***

Dates of Service From/To	Type of Service(s)	Agency that Provided the Service(s)	City	State

CURRENT EMPLOYMENT

Name of Employer	Job Title	Hire Date	Wage	Location

PREVIOUS EMPLOYMENT

Name of Employer	Job Title	Dates of Employment	Wage	Location

TRANSPORTATION

TRANSPORTATION ***(check all that apply)***

- ☐ Uses City Bus/Cab Independently
- ☐ Family/Friends Provide Transportation
- ☐ Operates Own Vehicle (Car/Bike)
- ☐ Uses Para Transit (Metro Lift)
- ☐ Agency (group home) Provides Transportation
- ☐ Other, _____

Comments: _____

_____

THE CENTER
APPLICATION FOR SERVICES / ENROLLMENT FORM

NAME:_____ **DOB:** _____ **DATE:** _____

Has the Applicant ever been Convicted (or adjudicated) of a public offense? ☐ No ☐ Yes
If yes, will the conviction interfere with the admission at The Center? ☐ No ☐ Yes

If yes, please explain: _____

_____

_____

Please submit documents requested on the Application for Services Documentation Checklist.

Your application will not be considered complete until all documents have been given to The Center's Admissions Coordinator.

Please contact The Center's Admissions Coordinator (713) 525-8318 with any questions or for assistance.

I agree that the information provided is, to the best of my ability, accurate and complete.

_____ _____
Applicant Signature **Date** **Guardian Signature** **Date**

_____
Witness Signature **Date**

Form #151 – 01/98
Revised 09/15

THE CENTER
ADMISSION FUNDING DATA

NAME OF INDIVIDUAL: _____
Last Name First Name Middle Initial

PRESENT ADDRESS: Street Address**:** _____

City**:** _____ State**:** _____ Zip**:** _____

PHONE NUMBER: [Home] **(____)**_____ [Other/Emergency] **(____)**_____

DATE OF BIRTH: _____ **GENDER:** ☐ Male ☐ Female

SOCIAL SECURITY NUMBER: _____

PROGRAM(S)	LOCATION CODE	ADMISSION DATE	FUNDING SOURCE(S)	FUNDING AMOUNT
Adult Activity Center	**AAC**			
ATES - Caning	**CAN**			
ATES - West Dallas Day Habilitation Classroom	**DHC**			
ATES - West Dallas Day Habilitation Workshop	**DHW**			
ATES - West Dallas Vocational Workshop	**WDW**			
ATES - Young At Heart	**YAH**			
Cullen - Assisted Living	**AL**			
Cullen - Independent Living	**IL**			
Willow River Farm - Residential	**WRF**			
Willow River Farm - Assisted Living	**WRFAL**			
Willow River Farm – Day Habilitation	**WRFDH**			

INVOICE MAILING ADDRESS:

Street Address: _____

City: _____ State: _____ Zip: _____

COMMENTS:_____

_____

_____

_____

_____
Signature of Program Director/Manager **Date**

_____
Signature of Admission Coordinator **Date**

Send a copy to Accounting within 5 working days prior to entry date; original submitted with Intake Checklist to Records.

Location:_____

Case #:_____

Form #18 – 03/79
Revised 09/12

The Center

ADMISSION MEDICATION HISTORY

NAME:_____ DATE OF BIRTH:_____

List any allergic reactions to medications:_____

A. CURRENT MEDICATIONS:

Name of Medication Presently Prescribed	Reason for Medication	Date Prescribed	Prescribing Doctor	No. of Times per Day	How Much Medicine Each Time	Where is Medication Taken

B. PAST MEDICATIONS

Name of Medication Prescribed	Reason for Medication	Date Prescribed	Date Discontinued

SIGNATURE:_____ DATE:_____
(Individual / Parent / Guardian)

The Center
3550 West Dallas Houston, Texas 77019
(713) 525-8400

REPORT OF PHYSICAL EXAMINATION

NAME: _____ **DATE OF BIRTH:** _____ **M**____ **F**____

SECTION I - Condensed Medical History: _____

_____

_____

_____

Known Allergies: _____

SECTION II - Medication Presently Prescribed and Reason for Use: _____

_____

_____

_____

SECTION III - Results of Physical Examination:

HT: _____ **WT:** _____ **PULSE RATE:** _____ **BLOOD PRESSURE:** _____

NUTRITIONAL STATUS: _____ **Good** _____ **Fair** _____ **Poor - Recommendations (DIET):**

_____

EYES: _____ **Normal** _____ **Abnormal - Comments:** _____

_____

Describe ability to see: _____

Visual Acuity: R. 20/_____ **L. 20/**_____ **With glasses: R. 20/**_____ **L. 20/**_____

EARS: _____ **Normal** _____ **Abnormal - Comments:** _____

_____

Describe ability to hear: _____

NOSE: _____

MOUTH: _____

THROAT & NECK: _____

BREAST: _____

THORAX & LUNGS: _____

NAME: _____ **DATE OF BIRTH:** _____

CIRCULATORY SYSTEM: Heart _____

EXTREMITIES: _____

ABDOMEN: _____

HERNIAS: _____

GENITO-URINARY-GYNECOLOGICAL & RECTAL: _____

_____

OSSEOUS & MUSCULAR SYSTEM: _____

SKIN: _____

NEUROLOGICAL: _____

MENTAL STATUS: _____
If on psychoactive medication, note any Side Effects and results of Assessment of Involuntary Movement:

_____

HISTORY OF SEIZURES: _____ **No** _____ **Yes, list type:** _____
If on anticonvulsant medication, comment on any side-effects noted:

_____

DIAGNOSTIC FINDINGS AND/OR IMPRESSIONS: _____

_____

Is this person free from communicable diseases? _____ **YES** _____ **NO - If No, Explain:** _____

_____

Is this person able to attend program without restrictions? _____ **YES** _____ **NO - If No, Specify:** _____

_____

OTHER EXAMINATIONS/LABORATORY TESTS NEEDED: _____

_____

(Forward results when completed)

_____
Physician's Signature

_____
Print or Type Physicians Name

_____

_____
Full Address and Telephone Number

_____
Date of Examination

FOR AGENCY USE ONLY:

Reviewed by: _____

Date: _____

RESIDENTS ONLY:

The above results have been explained to me.

_____
Resident's Signature

THE CENTER

PHYSICIAN'S ORDERS FOR SELF-ADMINISTRATION OF MEDICATION

NAME: _____CASE#: _____

Date of most recent self-medication assessment: _____

Date of Support Team meeting to develop recommendations: _____

Support Team Recommendations *Check appropriate blanks*	**Doctor Order** *(if applicable)* *Check appropriate blanks*	
		Individual can self medicate with minimal supervision.*
		Individual can apply treatments with minimal supervision.*
		Individual can self medicate with moderate supervision.*
		Individual can apply treatments with moderate supervision.*
		Individual can self medicate with maximum supervision.*
		Individual can apply treatments with maximum supervision.*
		Individual can self-administer medication independently.
		Individual can apply medical treatments independently.
		Individual requires administration of medication.
		Individual requires administration of treatments.

***Supervised Administration of Medication:** A system by which the person served removes medication from its container and takes the medication all under the supervision of a person that has successfully completed training in supervision of medication administration.

Completed by: _____Date: _____
(Physician's signature)

Signature: _____Date: _____
(Individual/Parent/Guardian/LAR)

Reviewed by: _____Date: _____
(Program Coordinator / QDDP / Service Monitor)

Location: _____

Case #: _____

The Center
3550 West Dallas
Houston, Texas 77019
(713) 525-8400

Form #8 - 08/84
Revised 09/12
Non-Residential Services

PHYSICIAN'S REQUEST FOR ADMINISTRATION OF MEDICATION

Name: _____ Birth Date: _____ Date: _____

Diagnosis: _____

Allergies: _____

Reason for referral to physician: _____

Diet: _____

CURRENT ORDERS: Signature of physician indicates these orders are renewed unless discontinued in new order section below.

Medication / Strength	Route	Directions	No. Units / Stop Order Date	Medication / Strength	Route	Directions	No. Units / Stop Order Date

NEW ORDERS: 1) Generic Equivalent approved for use on all legend and non-legend medications unless otherwise indicated. 2) Please indicate calendar-date stop order for each medication ordered. Medications for behavior management must, according to standards under which The Center operates, have a calendar date stop order of 30 days or less.

Medication / Strength	Route	Directions	No. Units / Stop Order Date	Medication / Strength	Route	Directions	No. Units / Stop Order Date

Activity Restrictions: _____

TEST RESULTS: Please indicate any laboratory tests, x-rays, blood levels, etc. performed. You will be called for results if they are unavailable at time of this report (continue on reverse side if necessary). _____

_____

Return Appointment Date / Time: _____ / _____

Physician's Signature: _____ Date: _____

(Please print or type the Physician's Name, Office Address & Telephone Number on the line below.)

_____

Signature of Nurse Receiving Orders (LVN/RN) _____ Date / Time _____ / _____

This is your permission to administer the above medications, treatments, and/or procedures as requested by physician.

Signature of Individual / Guardian: _____ Date: _____

Location:_____ The Center Form #09 - 7/78

Case #:_____ Revised 09/12

HEARING SCREENING

Name:_____ Birthdate:_____

Date:_____

Examiner:_____

Reason for

testing_____

Type of Test: __Otoscopic __Puretone __Impedence / Behavior: __Cooperative __Uncooperative

Activity: __Sitting __Raising Hand Test Results Were: __Reliable __Unreliable

Otoscopic Exam: Right:_____

Left:_____

Comments:_____

_

Pure Tone Testing: Right:_____

Left:_____

Comments:_____

_

_____

_

Impedence Testing: Right:_____

Left:_____

Comments:_____

_

_____

_

Recommendations:_____

_

_____

_

Referral

Information:_____

_____

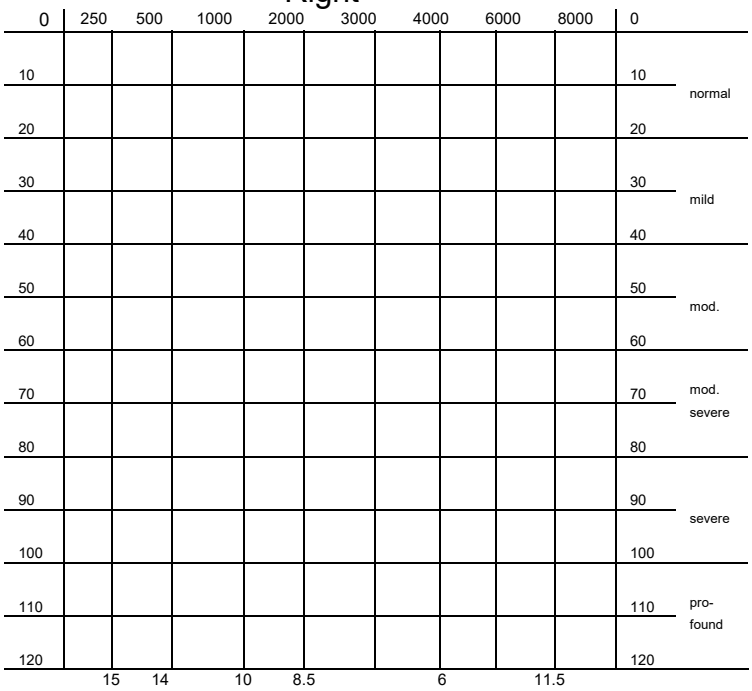
_

Location:_____ The Center Form #09 - 7/78

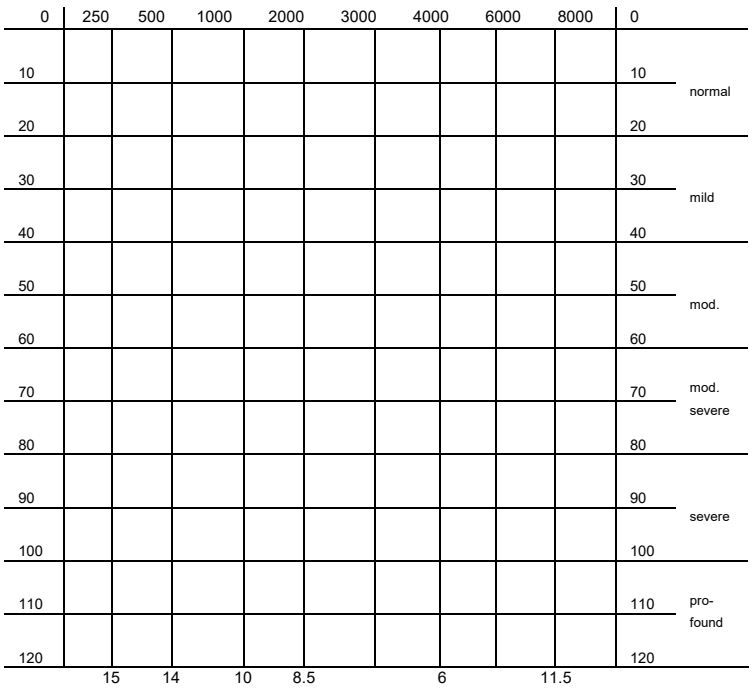
Case #:_____ Revised 09/12

HEARING SCREENING

Right



Left



Location:_____ The Center Form #10

Case#:_____ Revised 09/12

3550 West Dallas - P.O. Box 130564
Houston, Texas 77019 (713) 525-8400

VISION SCREENING

Name:_____ Date of Birth:_____

Date:_____ Examiner's Signature:_____
Doctor:_____ Address:_____
Med Allergies:_____
Food Allergies: _____ Phone:_____

Reason for Testing:_____

_____

1. TRACKING (Penlight)
   Comments:_____

2. VISUAL ACUITY
   Snellen E_____ Symbol Chart_____

   Snellen Letters_____ Flash Cards_____

   Hand Chart_____ Other_____

   Vision without glasses: Both eyes_____ Right eye_____ Left eye_____

   Vision with glasses: Both eyes_____ Right eye_____ Left eye_____

   Comments:_____

3. PERIPHERAL: Right degree:_____ Left degree:_____

4. OBSERVATION OF EYES:_____

   _____

5. OTHER VISION TEST: Type:_____

   Comments:_____

6. GLAUCOMA: Right pressure:_____ Left pressure:_____

7. RECOMMENDATIONS:_____

   _____

   _____

8. REFERRAL INFORMATION:_____

   _____

   _____

Location:_____ Form #11, 5/84

Case#:_____ Revised 09/12

The Center
3550 West Dallas - P.O. Box 130564
Houston, Texas 77219-0564
(713) 525-8400

DENTAL EVALUATION REPORT - (Private Dentist)

Name: _____ Date of Birth:_____

Date of Exam: _____ Dentist (print):_____
Med Allergies: _____ Address: _____
Food Allergies: _____ Phone: _____

DESCRIPTION OF ORAL HYGIENE PRACTICES: (address practices in flossing, brushing, type of dentrifice used and how often practices are conducted)

Are oral hygiene practices adequate? ☐Yes ☐No - (if no, please explain and give recommendations for training)

RESULTS OF INTRA AND EXTRA ORAL EXAMINATION:
☐ Within Normal Limits ☐Abnormal (please explain)

Oral Hygiene (please check one): ☐Good ☐Fair ☐Poor

TREATMENT GIVEN:

FOLLOW-UP NEEDED:

INDIVIDUAL'S RESPONSE TO TREATMENT: ☐Cooperative ☐Uncooperative

Comments:

Date of Recall Appointment:_____

Signature:_____ Date:_____

Location: _____ Form #120 – 11/2007
Revised 05/13

Case # _____

The Center

3550 West Dallas - Houston, Texas 77019
MAIN 713-525-8400 FAX 713-525-8493

Tetanus/Diphtheria (Td) Immunization

INDIVIDUAL _____ DATE _____

DATE OF BIRTH _____ SOCIAL SECURITY # _____

As part of our Admissions process, The Center requires all individuals enrolled in one or more of our programs to have a Td shot, which is a combination immunization providing immunity against tetanus and diphtheria for individuals 13 years and older.

Although not required, it is highly recommended that your Td immunization be updated every 10 years.

Please indicate date Td Immunization was given: _____

Form must be signed by the Primary Care Physician or the Licensed Nurse who administered the immunization.

Primary Care Physician's Name: _____

Primary Care Physician's Signature: _____

Date Signed: _____

Licensed Nurse's Name: _____

Licensed Nurse's Signature: _____

Date Signed: _____

Once the immunization has been recorded, **please return the form to The Center / Admissions Department at 3550 West Dallas, Houston, Texas 77019.**

Original: Individual Master Record

Location: _____

Case #: _____

Form #165
Revised 09/12

THE CENTER

SEIZURE CLASSIFICATIONS

Individual Name: _____ Date Of Birth: _____

Seizure Classification Number(s): _____

Please indicate above the number and/or numbers of the following that describe the seizure activity noted for the individual being classified.

SEIZURE TYPES:

I. **GENERALIZED TONIC-CLONIC** (formerly called Grand Mal)
Characteristics: Sudden cry, fall, rigidity, followed by muscle jerks, shallow breathing or temporarily suspended breathing, bluish skin, possible loss of bladder or bowel control, usually lasts a couple of minutes. Normal breathing then starts again. There may be some confusion and/or fatigue, followed by return to full consciousness.

II. **ABSENCE** (formerly called Petit Mal)
Characteristics: A blank stare, beginning and ending abruptly, lasting only a few seconds, most common in children. May be accompanied by rapid blinking, some chewing movements of the mouth. Child is unaware of what's going on during the seizure, but quickly returns to full awareness once it has stopped. May result in learning difficulties if not recognized and treated.

III. **SIMPLE PARTIAL**
Characteristics: Jerking may begin in one area of body, arm, leg, or face. Can't be stopped, but patient stays awake and aware. Jerking may proceed from one area of the body to another, and sometimes spreads to become a convulsive seizure. Partial sensory seizures may not be obvious to an onlooker. Patient experiences a distorted environment. May see or hear things that aren't there, may feel unexplained fear, sadness, anger, or joy. May have nausea, experience odd smells, and have a generally "funny" feeling in the stomach.

IV. **COMPLEX PARTIAL** (also called Psychomotor or Temporal Lobe)
Characteristics: Usually starts with blank stare, followed by random activity. Person appears unaware of surroundings, may seem dazed and mumble. Unresponsive. Actions clumsy, not directed. May pick at clothing, pick up objects, try to take clothes off. May run, appear afraid. May struggle or flail at restraint. Once pattern established, same set of actions usually occur with each seizure. Lasts a few minutes, but post-seizure confusion can last substantially longer. No memory of what happened during the seizure period.

V. **ATONIC SEIZURES** (also called Drop Attacks)
Characteristics: A child or adult suddenly collapses and falls. After 10 seconds to a minute he recovers, regains consciousness, and can stand and walk again.

VI. **MYOCLONIC SEIZURES**
Characteristics: Sudden brief, massive muscle jerks that may involve the whole body or parts of the body. May cause person to spill what they were holding or fall off a chair.

VII. **INFANTILE SPASMS**
Characteristics: These are a cluster of quick, sudden movements that start between three months and two years of age. If a child is sitting up, the head will fall forward, and the arms will flex forward. If lying down, the knees will be drawn up, with arms and head flexed forward as if the baby is reaching for support.

VIII. **UNCLASSIFIED**

Signature of Physician or Nurse Date

Location: _____

Case # _____

Form #76 – 03/05
Revised 09/12

The Center

3550 West Dallas - Houston, Texas 77019
MAIN 713-525-8400 FAX 713-525-8493

ANNUAL TB TEST

INDIVIDUAL _____ DATE _____

DATE OF BIRTH _____ SOCIAL SECURITY # _____

Annual TB skin testing is recommended for all individuals served at The Center. Please provide your primary care physician with this form to have your skin test administered and/or read. Should the results of your skin test be positive, you are required to have a chest x-ray before you may return to The Center. Also, if you are a known positive reactor, you should have a chest x-ray every two years, or as often as recommended by your primary care physician.

Know the signs and symptoms of TB, which include but are not limited to: **PRODUCTIVE AND PROLONGED COUGH, COUGHING UP BLOOD, FEVER, CHILLS, LOSS OF APPETITE, WEIGHT LOSS, FATIGUE/WEAKNESS, OR NIGHT SWEATS.**

( ) ANNUAL SKIN TEST ( ) CHEST X-RAY ( ) EXEMPT

Once the TB test and/or Chest X-Ray have been read and the results recorded on this form, **please return this form to The Center / Records Department at 3550 West Dallas, Houston, Texas 77019.**

LICENSED NURSING STAFF ONLY:

Lot #_____

DATE OF TEST: _____

Expires: _____

SITE: LEFT ____ RIGHT ____

ADMINISTERED BY: _____

DATE READ: _____ **(Results of skin test must be read 48-72 hours after the test is administered.)**

RESULTS: POSITIVE ____ Millimeters NEGATIVE ____

READ BY: _____

CHEST X-RAY RESULTS (if applicable)

LICENSED STAFF ONLY:

DATE OF X-RAY: _____ ADMINISTERED BY: _____

RESULTS: POSITIVE ____ NEGATIVE ____ READ BY: _____

Original: Individual Master Record

Location: _____
Case No: _____

Form #41 – 02/89
Revised – 09/12

The Center

EMERGENCY INFORMATION AND AUTHORIZATION

NAME _____ Date Of Birth _____ SSN _____

ADDRESS _____ HOME PHONE _____

KNOWN ALLERGIES _____

EXISTING MEDICAL CONDITIONS (such as seizures, diabetes, etc) _____

PRIMARY CARE PHYSICIAN _____ OFFICE PHONE _____

PRIMARY DENTIST _____ OFFICE PHONE _____

HOSPITAL PREFERENCE _____ PHONE _____

MENTAL HEALTH PROVIDER _____ PHONE _____

PHARMACY PREFERENCE _____ PHONE _____

FUNDING SOURCE: _____ FUNDING SOURCE CASE #: _____

(IF YOU DO NOT HAVE MEDICAID, AND/OR PRIMARY INSURANCE, PLEASE WRITE "NONE" IN THE APPROPRIATE BLANKS.)

PRIMARY INSURANCE _____ POLICY HOLDER _____

POLICY # _____ GROUP # _____ PHONE # _____

MEDICAID # _____ MEDICARE # _____ ADVANCE DIRECTIVE (on file) ___ NO ___ YES

GUARDIAN ___ NO ___ YES DURABLE POWER OF ATTORNEY FOR HEALTHCARE ___ NO ___ YES

(IF YOU CHECKED "YES" ON EITHER OF THE OPTIONS ABOVE, PLEASE COMPLETE BELOW.)

Name _____ Home Phone _____ Work Phone _____ Cell Phone _____

Address _____ Relationship _____ E-Mail _____

NAMES & TELEPHONE NUMBERS OF PEOPLE WHO MAY BE CALLED IN THE EVENT OF AN EMERGENCY:

Parents _____ Home Phone _____ Work Phone _____ Cell Phone _____

Address _____ Relationship _____ E-Mail _____

Name _____ Home Phone _____ Work Phone _____ Cell Phone _____

Address _____ Relationship _____ E-Mail _____

Name _____ Home Phone _____ Work Phone _____ Cell Phone _____

Address _____ Relationship _____ E-Mail _____

I hereby authorize a representative of The Center to render first aid and in the event of an emergency requiring immediate medical attention, to seek care through a physician or emergency room.

INDIVIDUAL'S SIGNATURE _____ DATE _____

GUARDIAN'S SIGNATURE _____ DATE _____
(If applicable.)

WITNESS' SIGNATURE _____ DATE _____
(Only when individual's signature is illegible.)