

TO BE COMPLETED, SIGNED AND DATED ONLY BY PHYSICIAN OR CNP

(PLEASE PRINT)

Participant's Name _____
 Birth Date ___/___/___ Sex ___ Height ___ Weight ___ BP ___ Temp ___ Pulse ___ Resp. ___
 Physician Name _____
 Phone (_____) _____ Fax (_____) _____
 Diagnosis _____

Please return by:
 Mail: Client Services
 Stepping Stones
 5650 Given Rd.
 Cincinnati, OH 45243
 PDF:
 jeannie.ludwig@steppingstonesohio.org
 Fax: 1-877-913-1293

COMPLETE MEDICAL AND PHYSICAL HISTORY

(check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> ADD | <input type="checkbox"/> Mental Health Disorder |
| <input type="checkbox"/> ADHD | <input type="checkbox"/> Bi-Polar |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> OCD |
| <input type="checkbox"/> Aspergers | <input type="checkbox"/> Schizophrenia |
| <input type="checkbox"/> Auditory Impairment (circle correct side) | <input type="checkbox"/> Other _____ |
| Hearing Aid left right | <input type="checkbox"/> Paraplegia |
| P.E. Tubes left right | <input type="checkbox"/> Prader-Willi Syndrome |
| Cochlear Implant left right | <input type="checkbox"/> Quadriplegia |
| <input type="checkbox"/> Autism Spectrum Disorder | <input type="checkbox"/> Respiratory Disorder |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Asthma <input type="checkbox"/> Inhaler <input type="checkbox"/> Nebulizer <input type="checkbox"/> C-Pap |
| <input type="checkbox"/> Brain Injury | <input type="checkbox"/> COPD |
| <input type="checkbox"/> Cardiac Diagnosis | <input type="checkbox"/> Tracheostomy |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Circulatory Disorder | <input type="checkbox"/> Sensory Processing Disorder |
| <input type="checkbox"/> PVD | <input type="checkbox"/> Seizure Disorder |
| <input type="checkbox"/> Atherosclerosis | Type _____ |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> Spina Bifida |
| <input type="checkbox"/> Communicable Disease | <input type="checkbox"/> Shunt |
| Describe _____ | Type _____ |
| <input type="checkbox"/> Dermatological Condition | Location _____ |
| Describe _____ | <input type="checkbox"/> Uses Wheelchair <input type="checkbox"/> Manual <input type="checkbox"/> Electric |
| <input type="checkbox"/> Developmental Disability | <input type="checkbox"/> Visual Impairment |
| <input type="checkbox"/> Down Syndrome | <input type="checkbox"/> Glasses <input type="checkbox"/> Contacts |
| <input type="checkbox"/> Gastrointestinal Conditions: | Additional Diagnosis: _____ |
| <input type="checkbox"/> Celiac Disease <input type="checkbox"/> Crohn's Disease | _____ |
| <input type="checkbox"/> Other _____ | _____ |
| <input type="checkbox"/> Hydrocephalus | _____ |
| <input type="checkbox"/> Learning Disability | _____ |
| <input type="checkbox"/> Microcephalus | _____ |

<input type="checkbox"/> NOT APPLICABLE	ALLERGIES (food, environmental, seasonal, medications, insects, other)
<u>Allergy</u>	<u>Signs & Symptoms</u>
<u>Treatment</u>	
_____	_____
_____	_____
_____	_____

<input type="checkbox"/> NOT APPLICABLE	EPI-PEN (MUST BE PROVIDED BY PARENT/GUARDIAN)
Administered for SEVERE allergic reactions to _____	Dosage _____
If Epi-Pen is administered, 911 will always be called	

Physician Name (print) _____ Signature _____ Date ___/___/___

Participant Name _____ **Date of Birth** ___/___/___

<input type="checkbox"/> NOT APPLICABLE	SEIZURE TREATMENT PROTOCOL (Treatment order and EMERGENCY PLAN)
Treatment Order Date ___/___/___ Treatment: ___ VNS (vagal nerve stimulator) magnet for seizure > ___ minutes ___ Versed/Nayzilam (nasal midazolam) _____ PRN for seizure > ___ minutes ___ Diastat (Rectal Gel) _____ mg rectally PRN for seizure > ___ minutes Other Medication: _____ (please specify) Comments _____ _____ <p align="center">If Diastat is administered, 911 will always be called</p>	

<input type="checkbox"/> DOES NOT TAKE PRESCRIPTION DRUGS	PRESCRIPTION/OTC DRUGS ATTACH CURRENT MEDICATION RECORD (must be signed and dated by medical provider) Due to state regulations, a doctor's signature is needed for the following PRN's: ___ Acetaminophen - Follow directions on packaging as needed ___ Ibuprofen - Follow directions on packaging as needed ___ Additional PRN Medication _____ ___ Additional PRN Medication _____ ___ Additional PRN Medication _____
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IMMUNIZATIONS Please attach a signed and dated printout of immunizations.

<input type="checkbox"/> NOT APPLICABLE	TB TEST/CHEST X-RAY*
TB Skin Test Date ___/___/___ Type: (circle one) PPD Mantoux Result: _____ Chest x-ray Date ___/___/___ Findings: _____ *not required for admission	

<input type="checkbox"/> NOT APPLICABLE	PERSONS WITH DOWN SYNDROME
___ Negative Cervical x-ray for Atlantoaxial Instability.* X-ray date ___/___/___ ___ Positive ___ Negative for clinical symptoms of Atlantoaxial Instability *not required for admission	

<input type="checkbox"/> NOT APPLICABLE	TOILETING INSTRUCTIONS
Colostomy Yes ___ No ___ Ileostomy Yes ___ No ___ Collection Bag Yes ___ No ___ Type _____ Catheter Yes ___ No ___ Type _____	

Physician Name (print) _____ **Signature** _____ **Date** ___/___/___

Participant Name _____ **Date of Birth** ___/___/___

ACTIVITY RESTRICTIONS

Is the individual restricted from participation in any activities (swimming, hiking, fitness activities, etc.)
Please explain: _____

Please check if the individual is subject to the following:

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Sunburn | <input type="checkbox"/> Frequent Colds | <input type="checkbox"/> Dizziness/Fainting Spells | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Frostbite | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Ear Infection | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Sore Throat | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Sinus Infection | <input type="checkbox"/> Nausea/Vomiting |
| <input type="checkbox"/> Skin Rash | <input type="checkbox"/> Hernia | <input type="checkbox"/> Must Not Get Water In Ears | <input type="checkbox"/> Stay Out of Water |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Heart Defect/Dise | <input type="checkbox"/> MRSA/VRE | <input type="checkbox"/> Dehydration |
| <input type="checkbox"/> Vaginal Infections | | <input type="checkbox"/> Decubiti/Skin Breakdown | |
| <input type="checkbox"/> Menstrual Problems | | <input type="checkbox"/> Urinary Infections | |

DIETARY NEEDS

Dietary Restrictions Yes _____ No _____

If Yes, please fill out below :

Is participant NPO at all times: Yes _____ No _____

Type of tube: Gastrostomy _____ Jejunostomy _____ Nasogastric _____

Type of formula: _____ Amount _____ Water Amount _____

Time(s): _____ Method of administration: (will be gravity flow unless stipulated)

Food Allergy: _____

Special Precautions: _____

NOT APPLICABLE

DIABETIC NEEDS

INSULIN SLIDING SCALE

Diet Requirements: (be specific) _____

Insulin: ___yes ___ no Type _____

Glucagon: ___ yes ___ no Protocol For Administration _____

Treatment for Hypoglycemia: _____

STEPPING STONES, INC. IS UNABLE TO ACCOMMODATE THE FOLLOWING HEALTHCARE NEEDS:

- Insulin Pump
- Oxygen Tank
- CPAP/Bi-PAP - We can only accommodate individuals that do not require monitoring throughout the night.
- Tracheostomies - Participants who have a trach must be able to provide their own nurse to tend to trach care during day program. At this time, we are unable to accommodate a participant with a trach at our overnight programming.

Physician Name (print) _____ **Signature** _____ **Date** ___/___/___