provincial assessment centre | COMMUNITY LIVING BRITISH COLUMBIA

REFERRAL PACKAGE
CAGEGIVER INFORMATION

Caregiver Section Completed by:

Name:	Tel:
Position held:	

Referred Individual

Name:

RESIDENTIAL INFORMATION

Type of Home: (i.e., Birth Family, Adoptive Family, Proprietary Care, Group Home, Semi-Independent / Independent Living)

How long in current home?

Other occupants? (e.g. Family members / Care provider)

Residential placements in last five years:

Type	Dates	Reason for moves

If individual lives in group home:

Number of individuals sharing home: Female ☐ Male ☐

Any recent changes of co-residents or staff in last 1-2 years: ☐

Is home environment settled ? : yes ☐ no ☐

Person in charge if in a group home

Name:	Tel:

What is the level of supervision? Days: ☐ Evenings: ☐ Nights: ☐

Placement on Discharge? Current Home: ☐ Other: (Specify)

Is current placement a problem? Yes ☐ No ☐ (why?)

What have you tried to resolve the situation?

How do you intend to resolve the issue(s)?

What other support services are received from outside the home?

Has a behavioural management plan been developed in the past? If so, explain the plan.

Please explain the crisis-response plan?

Are physical restraints used as an intervention?

ADAPTIVE BEHAVIOURS

Communication Styles:

Social Interaction Styles:

Interests:

Strengths:

CHALLENGING BEHAVIOURS

Problem	Frequency	Duration

DAY PROGRAM INFORMATION

Program

Title:	Tel:

Person-in-Charge

Name:	Tel:
Position held:	

How long has the individual been attending Day Program?

How effective has the Day Program been?

Day Program Placements in last 5 years: (if different)

Program	Location	Agency Phone #	Reasons for Moves

Attendance: (Days/Times)

What types of activities are focused on in this individual's Day Program? (i.e., vocational, educational, leisure, social)

What is the level of supervision?

Any specific problems or conflicts at the Day Program?

What have you tried to resolve these issues?

Has the individual ever been sent home from Day Program as a result of behaviour problems?

Are PRN medications used at the Day Program for this individual?

Are physical restraints ever used for this individual at the Day Program?

What is the crisis-response plan, and is it effective?

Does this individual attend paid or volunteer employment? (Offered through Day Program or Independent employer)

Other jobs in the last five years that were considered successful?

MEDICAL HISTORY

Family Physician

Name:	Tel:

Most recent physical examination: (state any abnormal findings)

Consultations with medical specialists in last five years:

Ongoing or recent physical health concerns: (i.e., seizure disorder, cerebral palsy)

Mobility Aids Used: (i.e., wheelchair, cane, leg braces, etc.)

MEDICATION ALLERGIES

Name of Medication	Nature of Allergic Reaction

Other Allergies: (i.e., food, airborne, skin, etc.)

Vaccination History: (specify dates) YYYY/MONTH/DD

Tetanus Booster:		TB History:	
Hep B Immunity:		HIV Tests:	
Hep B Carrier:		Flu Shots:	

HISTORY OF HOSPITALIZATIONS

(i.e., physical, medical, psychiatry, surgery, ECT, ICU admissions) Attach separate sheet if required.

Dates	Hospital/Facility	Reason	Diagnosis

Other conditions: (i.e., cytopenia, kidney issues, etc)

GENETIC HISTORY

Individuals Height: ______ **cm** **Weight:** ______ **kg**

Does the individual have a genetic syndrome diagnosis: (i.e., Down Syndrome. Please give diagnosis)

Has the individual had a karyotype: (chromosome analysis) YES ☐ **NO** ☐

If YES, was this: NORMAL: ☐ **ABNORMAL:** ☐

List any genetic investigations that were performed with a negative result: (i.e., Fragile X)

List physical or congenital abnormalities that were noticed at birth: (heart defect, club foot, hypospadias, hernia, etc.)

Describe any issues or diagnoses the individual has with respect to the following:

Skeletal problems: (i.e., scoliosis, osteopenia)

Craniofacial: (i.e., microcephaly, dysmorphism)

Muscular problems: (i.e., hypotonia)

Gastrointestinal problems:

Cardiac problems: (i.e., VSD, tetralogy of fallot)

Skin problems: (i.e., eczema, pigmented macules)

Opthalmological: (i.e., myopia, nystagmus, coloboma, etc.)

Seizures: ____________________ **Hearing:** ________________________

Thyroid function: (i.e., hyper/hypo)

Has the individual had any of the following:

EEG:	yes	☐	no	☐	**if yes**, normal:	☐	abnormal:	☐
ECG:	yes	☐	no	☐	**if yes**, normal:	☐	abnormal:	☐
MRI:	yes	☐	no	☐	**if yes**, normal:	☐	abnormal:	☐