Instructions for Completing the Emergency Individual Fact Sheet

- **Residential programs (CLAs, RCs, HABs only) will be responsible for completing fact sheets on all individuals receiving residential support and for providing a copy to the day program providing such service for each individual.**
- **Day programs (DSOs, SHEs, GSEs only) will be responsible for completing fact sheets for all individuals residing at residence program types not a part of this plan (e.g., family homes, Community Training Homes, etc.)**

The Emergency Information Fact Sheet is a MS Word 2000 document template (.dot) that is protected. All label blocks of the form are dark gray with white lettering; all field (data entry) blocks are white. You can Tab through the field blocks one at a time from the top to the bottom of the form to easily enter data. You can use your mouse if you wish to enter data fields as well. Question fields show YES (by default) but can be changed to NO by entering the field and clicking the down arrow: a small Yes/No graphic appears – simply click NO. To update changes, simply change the Completion/Update Date field to the date you are making changes and then update other fields as appropriate.

Installation: You can copy the document to the TEMPLATE directory on your computer and access it using FILE, NEW and then opening it (a new copy is made). You can also open it as an existing document in MS Word using FILE, OPEN and immediately save it using FILE, SAVE AS (You will need to set Files of Type in the OPEN dialog box to ALL FILES to see the document template name [file type is a .dot NOT .doc] to open it).

BE BRIEF AND DESCRIBE ONLY CRITICAL ISSUES ASSOCIATED WITH AN INDIVIDUAL'S SAFETY

Completion/UpdateDate:	Date this form is initially completed, and thereafter, date of update
Photo Date:	Date the individual's color photograph was taken
Individual:	Name of individual participating in program
DDS Number:	DDS number of individual
DOB:	Date of Birth of individual
Residential Address:	Residential address of individual
Provider: & Phone	Name of Provider/Agency serving the individual & phone number
Program & Address: & Phone	Name of Program & Address of Program serving the individual & phone number
Physician: & Phone	Name of individual's primary care physician & phone number
Pharmacy: & Phone	Name of individual's pharmacy & phone number
Medicaid Number:	Individual's Medicaid number
Family Contact: & Phone	Name of individual's primary family contact & phone number
Medical Guardian: & Phone	Name of individual's medical guardian & phone number
Blood Type (if known):	Individual's blood type, if known – if unknown, please acquire at next health care appointment
Medical Diagnoses:	Individual's medical diagnoses

Critical Requirement: Any requirement that can cause serious harm or death if not adhered to

Medications?	Yes or No
Meds Taken At Day Program?	Yes or No
Medical? & Description, if YES	Yes or No examples: g-tube, oxygen, repositioning, transfer lifting methods
Allergies? & Description, if YES	Yes or No examples: penicillin or other medications, bee sting, lactose, peanut butter
Dietary? & Description, if YES	Yes or No examples: food consistency (e.g., ground, pureed, chopped food items); restrictions (e.g., salt, calories, gluten, nuts)
Eating? & Description, if YES	Yes or No examples: hand -over-hand assistance, nothing by mouth (NPO)
Ambulation/Mobility? & Description, if YES	Yes or No examples: custom wheelchair, walker, cane, AFOs
Communication? & Description, if YES	Yes or No examples: speak close to him due to hearing loss; uses sign language; no apparent understanding of what you say; uses gestures frequently to communicate and acknowledges when you point to something
Adaptive Equipment? & Description, if YES	Yes or No examples: shower chair, hand splint, hospital bed, hip abduction braces, barrier free lift, transfer lift device
Supervision? & Description, if YES	Yes or No examples: inability to understand directions, expressive communication deficits, bathing & personal care, eats cigarette butts, choking, rapid eating, food or medication refusal, assault, self-abuse, running into the road
Behavior Management? & Description, if YES	Yes or No examples: written behavioral management plans addressing behavior such as – eats shoe laces, food or medication refusal, punches people indeterminately, self-abuse, running into the road, undue anxiety