

IDENTIFICATION/BACKGROUND

Name & Vital Information

Client Name: Butler Richard Lee Client SSN: _____
(Last) (First) (Middle Initial)
Address: 3315 Delaware Ave Richmond VA 23222
(Street) (City) (State) (Zip Code)
Phone: 1800- [REDACTED] City/County Code: 7 6 0
Directions to House: _____ Pets? _____

Demographics

Birthdate: 10 / 16 / 74 Age: 23 Sex: Male Female
(Month) (Day) (Year)
Marital Status: Married Widowed Separated Divorced Single Unknown
Race: White Black African American American Indian Oriental-Asian Alaskan Native Unknown
Education: Less than High School Some High School High School Graduate Some College College Graduate Unknown
Communication of Needs: Verbally, English Verbally, Other Language Sign Language/Gestures/Device Does Not Communicate Hearing Impaired
Specify: _____
Ethnic Origin: _____ Specify: _____

Primary Caregiver/Emergency Contact/Primary Physician

Name: Diane Butler Relationship: Mother
Address: See above Phone: (H) _____ (W) _____
Name: _____ Relationship: _____
Address: _____ Phone: (H) _____ (W) _____
Name of Primary Physician: Dr J Shield Phone: _____
Address: 7449 Johnke Rd Richmond VA 23225

Initial Contact

Who called: Dr J Shield Psychiatrist _____
(Name) (Relation to Client) (Phone)

Presenting Problem/Diagnosis:
Schizophrenia

EXHIBIT
1A (6-PAGES)

Sensory Functions

How is your vision, hearing, and speech?

	No Impairment 0	Impairment		Complete Loss 3	Date of Last Exa.
		Record Date of Onset/Type of Impairment			
		Compensation 1	No Compensation 2		
Vision					
Hearing					
Speech					

Physical Status

Joint Motion: How is your ability to move your arms, fingers and legs?

- Within normal limits or instability corrected 0
- Limited motion 1
- Instability uncorrected or immobile 2

Have you ever broken or dislocated any bones . . . Ever had an amputation or lost any limbs . . . Lost voluntary movement of any part of your body?

Fractures/Dislocations	Missing Limbs	Paralysis/Paresis
<input type="checkbox"/> None 000 <input type="checkbox"/> Hip Fracture 1 <input type="checkbox"/> Other Broken Bone(s) 2 <input type="checkbox"/> Dislocation(s) 3 <input type="checkbox"/> Combination 4 Previous Rehab Program? <input type="checkbox"/> No/Not Completed 1 <input type="checkbox"/> Yes 2 Date of Fracture/Dislocation? <input type="checkbox"/> 1 Year or Less 1 <input type="checkbox"/> More than 1 Year 2	<input type="checkbox"/> None 000 <input type="checkbox"/> Finger(s)/Toe(s) 1 <input type="checkbox"/> Arm(s) 2 <input type="checkbox"/> Leg(s) 3 <input type="checkbox"/> Combination 4 Previous Rehab Program? <input type="checkbox"/> No/Not Completed 1 <input type="checkbox"/> Yes 2 Date of Amputation? <input type="checkbox"/> 1 Year or Less 1 <input type="checkbox"/> More than 1 Year 2	<input type="checkbox"/> None 000 <input type="checkbox"/> Partial 1 <input type="checkbox"/> Total 2 Describe: _____ _____ Previous Rehab Program? <input type="checkbox"/> No/Not Completed 1 <input type="checkbox"/> Yes 2 Onset of Paralysis? <input type="checkbox"/> 1 Year or Less 1 <input type="checkbox"/> More than 1 Year 2

Nutrition

Height: _____ (inches)

Weight: _____ (lbs.)

Recent Weight Gain/Loss: No 0 Yes 1

Describe: _____

<p>Are you on any special diet(s) for medical reasons?</p> <ul style="list-style-type: none"> <input type="checkbox"/> None 0 <input type="checkbox"/> Low Fat/Cholesterol 1 <input type="checkbox"/> No/Low Salt 2 <input type="checkbox"/> No/Low Sugar 3 <input type="checkbox"/> Combination/Other 4 <p>Do you take dietary supplements?</p> <ul style="list-style-type: none"> <input type="checkbox"/> None 0 <input type="checkbox"/> Occasionally 1 <input type="checkbox"/> Daily, Not Primary Source 2 <input type="checkbox"/> Daily, Primary Source 3 <input type="checkbox"/> Daily, Sole Source 4 	<p>Do you have any problems that make it hard to eat?</p> <p>No 0 Yes 1</p> <ul style="list-style-type: none"> <input type="checkbox"/> <input type="checkbox"/> Food Allergies <input type="checkbox"/> <input type="checkbox"/> Inadequate Food/Fluid Intake <input type="checkbox"/> <input type="checkbox"/> Nausea/Vomiting/Diarrhea <input type="checkbox"/> <input type="checkbox"/> Problems Eating Certain Foods <input type="checkbox"/> <input type="checkbox"/> Problems Following Special Diets <input type="checkbox"/> <input type="checkbox"/> Problems Swallowing <input type="checkbox"/> <input type="checkbox"/> Taste Problems <input type="checkbox"/> <input type="checkbox"/> Tooth or Mouth Problems <input type="checkbox"/> <input type="checkbox"/> Other: _____
---	--

4 PSYCHO-SOCIAL ASSESSMENT

Cognitive Function

Orientation (Note: Information in italics is optional and can be used to give a MMSE Score in the box to the right.)

Person: Please tell me your full name (so that I can make sure our record is correct).

Place: Where are we now (state, county, town, street/route number, street name/box number)?
Give the client 1 point for each correct response.

Time: Would you tell me the date today (year, season, date, day, month)?

- Oriented 0
- Disoriented - Some spheres, some of the time 1
- Disoriented - Some spheres, all the time 2
- Disoriented - All spheres, some of the time 3
- Disoriented - All spheres, all of the time 4
- Comatose 5

Spheres affected: _____

Optional: MMSE Score

_____ (5)

_____ (5)

Recall/Memory/Judgement

Recall: I am going to say three words, and I want you to repeat them after I am done (House, Bus, Dog). Ⓢ Ask the client to repeat them. Give the client 1 point for each correct response on the first trial. Ⓢ Repeat up to 6 trials until client can name all 3 words. Tell the client to hold them in his mind because you will ask him again in a minute or so what they are.

Attention/ Concentration: Spell the word "WORLD". Then ask the client to spell it backwards. Give 1 point for each correctly placed letter (DLROW).

Short-Term: Ⓢ Ask the client to recall the 3 words he was to remember.

Long-Term: When were you born (What is your date of birth)?

Judgement: If you needed help at night, what would you do?

- No Yes :
- Short-Term Memory Loss?
 - Long-Term Memory Loss?
 - Judgement Problem?

_____ (3)

_____ (5)

Total: _____

Note: Score of 14 or below implies cognitive impairment

Behavior Pattern

Does the client ever wander without purpose (trespass, get lost, go into traffic, etc.) or become agitated and abusive?

- Appropriate 0
- Wandering/Passive - Less than weekly 1
- Wandering/Passive - Weekly or more 2
- Abusive/Aggressive/Disruptive - Less than weekly 3
- Abusive/Aggressive/Disruptive - Weekly or more 4
- Comatose 5

Type of inappropriate behavior: _____ Source of Information: _____

Life Stressors

Are there any stressful events that currently affect your life, such as . . . ?

- | | | | | | |
|--------------------------|---------------------------|--------------------------|-------------------------------|--------------------------|--------------------------|
| No 0 | Yes 1 | No 0 | Yes 1 | No 0 | Yes 1 |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | Change in work/employment | | Financial problems | | Victim of a crime |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | Death of someone close | | Major illness - family/friend | | Failing health |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | Family conflict | | Recent move/relocation | | Other: _____ |

Hospitalization/Alcohol - Drug Use

Have you been hospitalized or received inpatient/outpatient treatment in the last 2 years for health, alcohol or substance abuse problems?

No 0 Yes 1

Name of Place	Admit Date	Length of Stay/Reason

Do (did) you ever drink alcoholic beverages?

Never 0
 At one time, but no longer 1
 Currently 2
 How much: _____
 How often: _____

Do (did) you ever use non-prescription, mood altering substances?

Never 0
 At one time, but no longer 1
 Currently 2
 How much: _____
 How often: _____

If the client has never used alcohol or other non-prescription, mood altering substances, skip to the tobacco question.

<p>Have you, or someone close to you, ever been concerned about your use of alcohol/other mood altering substances?</p> <p><input type="checkbox"/> No 0 <input type="checkbox"/> Yes 1</p> <p>Describe concerns: _____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>Do (did) you ever use alcohol/other mood-altering substances with...</p> <p>No 0 Yes 1</p> <p><input type="checkbox"/> <input type="checkbox"/> Prescription drugs?</p> <p><input type="checkbox"/> <input type="checkbox"/> OTC medicine?</p> <p><input type="checkbox"/> <input type="checkbox"/> Other substances?</p> <p>Describe what and how often:</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>Do (did) you ever use alcohol/other mood-altering substances to help you...</p> <p>No 0 Yes 1</p> <p><input type="checkbox"/> <input type="checkbox"/> Sleep?</p> <p><input type="checkbox"/> <input type="checkbox"/> Relax?</p> <p><input type="checkbox"/> <input type="checkbox"/> Get more energy?</p> <p><input type="checkbox"/> <input type="checkbox"/> Relieve worries?</p> <p><input type="checkbox"/> <input type="checkbox"/> Relieve physical pain?</p> <p>Describe what and how often:</p> <p>_____</p>
--	--	--

Do (did) you ever smoke or use tobacco products?

Never
 At one time, but no longer 1
 Currently 2
 How much: _____
 How often: _____

Is there anything we have not talked about that you would like to discuss?

ASSESSMENT SUMMARY

Indicators of Adult Abuse and Neglect: While completing the assessment, if you suspect abuse, neglect or exploitation, you are required by Virginia law, Section 63.1 - 55.3 to report this to the local Department of Social Services, Adult Protective Services

Caregiver Assessment

Does the client have an informal caregiver?

No - Skip to Section on Preferences Yes 1

Where does the caregiver live?

- With client 0
- Separate residence, close proximity 1
- Separate residence, over 1 hour away 2

Is the caregiver's help . . .

- Adequate to meet the client's needs? 0
- Not adequate to meet the client's needs? 1

Has providing care to the client become a burden for the caregiver?

- Not at all 0
- Somewhat 1
- Very much 2

Describe any problems with continued caregiving:

Preferences

Client's preferences for receiving needed care: _____

Family/Representative's preferences for client's care: _____

Physician's comments (if applicable): _____

INDIVIDUALIZED SERVICE PLAN

Resident's Name: Richard Bette Person Completing Plan: Beard Duckfield Date Plan Completed: 11/25/97

Person Designated to Review, Monitor, Ensure Implementation, and Make Appropriate Modifications to Plan: Beard Duckfield

Persons Completing Plan Reviews and Dates:

Name	Date	Name	Date

Description of needs is based upon the UAI, medical reports, and any additional assessments necessary to meet the care needs of the resident.

A. If the resident lives in a building housing 19 or fewer residents, does the resident need to have a staff member awake and on duty at night? Yes No

B. Description of Needs and Date Identified	Services to be Provided	Persons Who will Provide Services	When and Where Services will be Provided	Expected Outcomes/Goals
ADLs Bath	assist with shower if needed check water temp	CNA on duty	ACR	to maintain daily hygiene
Medication	administer & monitor resident taking meds	Med tech or LPN	ACR	to avoid being hospitalized
Meals	three meals and a snack	ACR Staff	Dining Room	to get a balance meal and stay healthy
Money Management	fill out forms to Cant check coming in	office staff	ACR	to keep funds for resident needs
Behavior	Support and give encouragement	all staff	ACR	provide self esteem and keep resident appropriate mood