DD-097-1 -PF (11-06)

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Division of Developmental Disabilities

PRE-SERVICE PROVIDER ORIENTATION

INSTRUCTIONS: This form is to be completed by the provider and the individual and/or responsible party receiving services prior to the initiation of services. A copy MUST be retained by the provider and a copy sent to the District Office. The provider must also ensure that a General Consent and Authorization form is completed and retained by the provider.

PROVIDER INFORMATION

PROVIDER'S NAME *(Last, First, M.I.)*	EMPLOYER TAX NO.	AHCCCS ID NO.
Transitions for the Developmentally Disabled	510505436	

IS THERE ANY SPECIAL TRAINING REQUIRED?

☐ Yes ☐ No Describe:

Med Training Needed ☐ Yes ☐ No Seizure Management Training Needed ☐ Yes ☐ No

CRITICAL INFORMATION

INDIVIDUAL'S NAME *(Last, First, M.I.)*	ASSISTS NO.	BIRTHDATE
INDIVIDUAL'S ADDRESS *(No., Street, City, State, ZIP)*		
GUARDIAN/RESPONSIBLE PARTY'S NAME *(Last, First, M.I.)*	RELATIONSHIP	PHONE NO.
ADDRESS *(No., Street, City, State, ZIP)*		
EMERGENCY CONTACT'S NAME *(If other than responsible party)*	RELATIONSHIP	PHONE NO.
SUPPORT COORDINATOR'S NAME / OFFICE LOCATION		PHONE NO.
NAME OF ALTCS/DDD HEALTH PLAN	AHCCCS ID NO.	PHONE NO.
PRIMARY CARE PHYSICIAN'S NAME		PHONE NO.
ADDRESS *(No., Street, City, State, ZIP)*		
URGENT CARE FACILITY'S NAME		PHONE NO.
ADDRESS *(No., Street, City, State, ZIP)*		
OTHER HEALTH INSURANCE INFORMATION		

DAY PROGRAM *(If applicable)*

NAME OF DAY PROGRAM	PROGRAM TYPE	DAYS AND HOURS OF ATTENDANCE	TRANSPORTATION METHOD
DAY PROGRAM ADDRESS *(No., Street, City, State, ZIP)*			PHONE NO.

HEALTH – MEDICAL

CURRENT MEDICATIONS AND SIGNIFICANT HISTORICAL MEDICATION ISSUES:

MED LOG REQUIRED ☐ Yes ☐ No

SPECIAL MEDICATION INSTRUCTIONS

ALLERGIES TO:

Food ☐ Yes ☐ No Specify Medication ☐ Yes ☐ No Specify

Bee Stings ☐ Yes ☐ No Specify Other ☐ Yes ☐ No Specify

RECOMMENDED RESPONSE TO ALLERGIC REACTION

SEIZURES: ☐ Yes ☐ No

DESCRIBE	FREQUENCY	APPROXIMATE DURATION

RECOMMENDED RESPONSE TO SEIZURE ACTIVITY

ASSISTIVE DEVICES

VISION	HEARING	DENTAL APPLIANCES

PROTECTIVE DEVICES:

INSTRUCTIONS FOR USE	PURPOSE

OTHER INDIVIDUALIZED HEALTH CARE ROUTINES

DD-097-2-PF (11-06)

PRE-SERVICE PROVIDER ORIENTATION

INDIVIDUAL'S NAME *(Last, First, M.I.)*	ASSISTS NO.	BIRTHDATE

DIET

FOOD:

INDEPENDENT WITH UTENSILS	INDEPENDENT WITH SPECIFIC UTENSILS	REQUIRES LIMITED ASSISTANCE	REQUIRES SIGNIFICANT ASSISTANCE
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

DOES FOOD PRESENT A CHOKING HAZARD

☐ Yes ☐ No Required consistency of food ☐ Normal ☐ Chopped ☐ Puréed

SPECIAL DIET

TUBE FEEDING *(Special instructions required)*	EATING DISORDER *(Describe)*
☐ Yes ☐ No	☐ Yes ☐ No

BEVERAGES:

INDEPENDENT WITH ANY CUP/GLASS	INDEPENDENT WITH ADAPTIVE	REQUIRES LIMITED ASSISTANCE	REQUIRES SIGNIFICANT ASSISTANCE
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

INDEPENDENT IN OBTAINING/REQUESTING BEVERAGES

☐ Yes ☐ No Describe adaptive eating/drinking equipment

IF SPECIAL LIQUID INTAKE NEEDS DESCRIBE

SYSTEM FOR FLUID INTAKE *(If applicable)*

COMMUNICATION

COMMUNICATION SKILLS: *(Check as applicable)*

☐ Uses complex Sentences ☐ Uses simple sentences ☐ Signs ☐ Nods yes/no ☐ Gestures

DESCRIBE AUGMENTATIVE COMMUNICATION DEVICES *(If applicable)*

MOBILITY

BALANCE WHILE STANDING

☐ Excellent *(not an issue)* ☐ Moderate *(stumbles, etc)* ☐ Poor *(very unsteady; falls)*

UTILIZES ADAPTIVE AIDS FOR BALANCE ☐ Yes ☐ No

INDEPENDENT MOBILITY *(Check as applicable)*

☐ Crawling/scooting ☐ Kneeling ☐ Standing ☐ Walking ☐ Running ☐ Climbing

MOBILITY/BALANCE AIDS *(Check as applicable)*

☐ N/A ☐ Walker ☐ Cane ☐ Crutches ☐ AFOs ☐ Leg Braces ☐ Wheelchair ☐ Other *(Specify)*

POSITIONING INSTRUCTIONS	LIFTING/CARRYING INSTRUCTIONS

PERSONAL CARE SKILLS *(Check all applicable items)*

	DRESSING	TOILETING	BATHING	DENTAL CARE	MENSES	MED. ADMIN.	OTHER
Independent	☐	☐	☐	☐	☐	☐	☐
Requires Prompting/reminding	☐	☐	☐	☐	☐	☐	☐
Requires Limited assistance/ supervision	☐	☐	☐	☐	☐	☐	☐
Requires significant assistance	☐	☐	☐	☐	☐	☐	☐

IF APPLICABLE, DESCRIBE SPECIAL PERSONAL CARE NEEDS AND PREFERENCES

BEHAVIORAL CONCERNS *(If applicable)* CIT Training ☐ Yes ☐ No

BRIEF DESCRIPTION	APPROXIMATE FREQUENCY	RECOMMENDED INTERVENTION
Aggression		
Self-Injurious Behavior		
Property Destruction		
AWOL		
Self Stimulation		
Sexual Acting Out		
Other		

IS A BEHAVIOR TREATMENT PLAN AVAILABLE FOR ADDITIONAL INFORMATION ☐ Yes ☐ No	REASON FOR BTP
METHOD USED TO OBTAIN INFORMATION (In person, case file, etc)	

SIGNATURES

SIGNATURE OF PERSON COMPLETING IF NOT RESPONSIBLE PARTY	RELATIONSHIP	DATE
PRINT PROVIDER'S NAME	PROVIDER'S SIGNATURE	DATE
PRINT RESPONSIBLE PERSON/GUARDIAN'S NAME	RESPONSIBLE PERSON/GUARDIAN'S SIGNATURE	DATE

Parents Email: _____

TRANSITIONS
for the Developmentally Disabled

I have reviewed the Pre-Service Provider Orientation and the Risk Assessment for:

Print Responsible Person/Guardian Name:_____

Responsible Person/Guardian Signature: _____Date:_____

(Client's Name): _____

Provider Signatures:

Printed Name:

_____Signautre:_____Date:_____

Printed Name:

_____Signautre:_____Date:_____

Printed Name:

_____Signautre:_____Date:_____

Printed Name:

_____Signautre:_____Date:_____

Printed Name:

_____Signautre:_____Date:_____

Printed Name:

_____Signautre:_____Date:_____

Printed Name:

_____Signautre:_____Date:_____

Printed Name:

_____Signautre:_____Date:_____

Printed Name:

_____Signautre:_____Date:_____