INVOLVEMENT PROFILE TOOL

NAME: ______________________________ **SS#** ______________

□ **Male** □ **Female** **DOB** ______________________

Move In / Transfer Date: ______________ **Time** ________

Coming from ____

New Room #:

PREFERRED NAME:	Previous Address (if coming from outside):
SOCIAL SUPPORT Responsible Party Name: ______________________________ Relationship: ☐ POA ☐ Guardian ☐ Family Phone #	Marital Status: ☐ Married ☐ Widowed ☐ Divorced Spouse's Name: ___________________________________ Other contacts / visitors:
INSURANCE Primary :_______ ___________________________________ ID # _________________________ Auth # ______________ Secondary: ________ ________________________________ ID # _________________________ MA # ___________________________ ☐ PP ☐PACE Other:	**MEDICAL INFORMATION** Do Not Resuscitate: ☐ Yes ☐ No ☐ Unknown at this time Living Will: ☐ Yes ☐ No ☐ Unknown at this time Organ Donor: ☐ Yes ☐ No ☐ Unknown at this time Allergies: ☐ No ☐ Yes, explain:
MEDICAL CONTACTS Attending Physician: _________________________________ Phone _____________________ Fax _________________ Dentist: _________________ Eye Care ___________________ Podiatrist ________________________ Hospital __________________ Ambulance _______________ Funeral Home _____________________________________	**SPECIALNEEDS / ORDERS:** DIETARY: _______________________________________ ____ Food Preferences: ________________________________ Food Restrictions: ________________________________ Laundry ☐ US ☐ Family Beautician/Barber ☐ Yes ☐ No D/C plan: ____
DIAGNOSIS / TREATMENTS DX: ____ ____ ____ ____ TX ☐ IV Meds ☐ IV Fluids ☐ TPN ☐ Trach ☐ Vent ☐ Suction NP or Trach ☐ Wound care Allergies: ____________________________________ Other:	**SELF-CARE STATUS:** Does he/she need help to ambulate? ☐ NO ☐ YES Does he/she need help to transfer? ☐ NO ☐ YES Is there a history of falls? ☐ NO ☐ YES Does he/she need help with feeding self? ☐ NO ☐ YES Does he/she need help with dressing self? ☐ NO ☐ YES Does he/she need help to toilet? ☐ NO ☐ YES Any special undergarments needed? ☐ NO ☐ YES Adaptive devices: ______________________________ Other:

INVOLVEMENT TOOL Name: ______________________________

COGNITIVE STATUS:	**PSYCHOSOCIAL STATUS:**
☐ No cognitive problems ☐ Mild	☐ No psychosocial problems ☐ Anxious ☐ Depressed
☐ Moderate ☐ Severe	☐ Fearful
☐ Dependent on others to make decisions	☐ History of defensive behavior (hitting, kicking etc.)
☐ Unable to communicate and make needs known	Other:
Other:	

INVOLVEMENT PREFERENCES

DAILY ROUTINE:

Wake up time: _________

Breakfast time: ______ Lunch time: ______ Dinner time: _______

Snack time: ________

Productive time: _________ What: _________________________

____

Leisure time: ______ What: ______________________________

____

Bathing time: _______ How: ______________________________

Nap Time: ___________ Bed Time: ____________

Other:

PRODUCTIVE PREFERENCES:	**LEISURE PREFERENCES**:
☐ Arts / Crafts ______________________	☐ Music – listening, playing ______________________
☐ Fitness / Sports ______________________	☐ Cards ______________________
☐ Puzzles ______________________	☐ Table Games ______________________
☐ Brain Exercises ______________________	☐ Animals ______________________
☐ Outdoors / Gardening ______________________	☐ Pets ______________________
☐ Cooking / Baking ______________________	☐ TV ______________________
☐ Computer / Email ______________________	☐ Movies ______________________
☐ Hobbies ______________________	☐ Other ______________________
☐ Special Interests ______________________	
☐ Other ______________________	

☐ Other pertinent information:

Completed by:
Signature:______________________________________ Date:____________________