THE ANNE SIPPI CLINIC

PREADMISSION QUESTIONAIRE

The following questionnaire is designed to assist our staff in identifying specific issues that may affect the placement of and/or services to be provided to prospective residents of our facilities. Please review the questions on this list, and answer as completely as possible. This form is intended to provide information needed in developing a plan of care, and evaluating suitability for placement. This form was developed through consultation with Community Care Licensing, technical support division.

Date: _____

Applicant's Name: _____

Current Residence: _____
_____
_____
_____
_____

YES **NO**

[] [] Is the client a registered sex offender? (Information required per H & S 1522.01) If yes, provide information on offense (s) _____
_____
_____

A. MENTAL/DEVELOPMENTAL STATUS

Does the client have any of the following diagnosis:

YES	NO		
[]	[]	1.	Mental disorder
[]	[]	2.	Developmental disability
[]	[]	3.	Dual Diagnosis

1. If the answer to any of the above is yes, please describe:

The condition:

_____
_____
_____
_____
_____

The severity of the disorder or disability:

_____
_____
_____

Any current or previous treatment:

_____
_____
_____

B: HEALTH STATUS

Client's primary physician name and phone: _____
_____

Does the client use prescription medications? If yes please list prescriptions:
_____
_____
_____

Does the client use any nonprescription medications? If yes please list medications:
_____
_____
_____

Does the client have any of the following:

YES	**NO**		
[]	[]	1.	Asthma
[]	[]	2.	Epilepsy
[]	[]	3.	Allergies
[]	[]	4.	Diabetes
[]	[]	5.	Eating disorders
[]	[]	6.	Visual impairment
[]	[]	7.	Physical impairment
[]	[]	8.	Infection disease
[]	[]	9.	Special Diet
[]	[]	10.	Pregnancy
[]	[]	11.	Chronic medical condition
[]	[]	12.	Incontinence

If the answer to any of the above is yes, please describe:

Type and severity of the condition: _____

_____
_____
_____

The treatment the client is receiving for the condition: _____
_____
_____
_____

The name and dosages of medications the client receives: _____
_____
_____
_____

Any medical apparatus the client needs as a result of the condition: _____
_____
_____
_____

Any limitations due to the condition: _____
_____
_____
_____

C: FUNCTIONAL STATUS

Do any of the following conditions apply to the client:

YES	**NO**		
[]	[]	1.	Non-ambulatory
[]	[]	2.	Bedridden/bed cast
[]	[]	3.	Paralysis
[]	[]	4.	Contracture
[]	[]	5.	Inability to transfer to and from bed
[]	[]	6.	Needs assistance with eating, dressing, bathing, grooming, or toileting

If the answer to any of the above is yes, please describe:

Type of limitation and its severity: _____
_____
_____
_____

Any assistive devices used by the client: _____

_____
_____
_____

Any treatment of therapy needed by the client as a result of the condition: _____
_____
_____
_____
_____
_____

D: BEHAVIORS

Does the client have a history of any of the following:

YES	NO		
[]	[]	1.	Physical assaultiveness
[]	[]	2.	Verbal assaultiveness
[]	[]	3.	Sexual assaultiveness or molestation
[]	[]	4.	Violence to self or others
[]	[]	5.	Cruelty to others
[]	[]	6.	Attempt to poison others
[]	[]	7.	Use of weapons
[]	[]	8.	Cruelty to animals
[]	[]	9.	Destruction of property
[]	[]	10.	Stealing
[]	[]	11.	Arson

If the answer to any of the above questions is yes, please describe:

The behaviors: _____
_____
_____
_____

The frequency and duration of the behaviors: _____
_____
_____
_____

The approximate date of the last occurrence of the behaviors: _____

_____
_____
_____

Anything that seems to trigger the behavior: _____
_____
_____

Strategies to deal with the behavior: _____
_____
_____

Does the client have a history of any of the following:

YES	**NO**		
[]	[]	1.	Depression or withdrawal
[]	[]	2.	Anxiety
[]	[]	3.	Mood swings
[]	[]	4.	Suicidal ideation
[]	[]	5.	Suicide attempts
[]	[]	6.	Paranoia
[]	[]	7.	Hallucination
[]	[]	8.	Restlessness or hyperactivity
[]	[]	9.	Inappropriate sexual activity
[]	[]	10.	Confusion with sexual identity
[]	[]	11.	Non-compliance
[]	[]	12.	Refusal to attend therapy

If the answer to any of the above is yes, please describe:

The behaviors: _____
_____
_____
_____

The frequency and duration of the behaviors: _____
_____
_____
_____

The approximate date of the last occurrence of the behaviors: _____
_____
_____

Anything that seems to trigger the behavior: _____
_____
_____
_____

Strategies to deal with the behavior: _____
_____
_____
_____

Does the client have a history of any of the following:

YES	**NO**		
[]	[]	1.	Disruptiveness
[]	[]	2.	Tantrums
[]	[]	3.	Wandering
[]	[]	4.	AWOL
[]	[]	5.	Substance abuse
[]	[]	6.	Ingestion of toxic substances
[]	[]	7.	Refusal of medications
[]	[]	8.	Refusal of medical treatment
[]	[]	9.	Refusal to bathe or wear clean clothes
[]	[]	10.	Resistance to authority
[]	[]	11.	Careless disposal of smoking materials

If the answer to any of the above is yes, please describe:

The behaviors: _____
_____
_____
_____

The frequency and duration of the behavior: _____
_____
_____
_____

The approximate date of the last occurrence of the behavior: _____
_____
_____
_____

Anything that seems to trigger the behavior: _____

_____
_____
_____

Strategies to deal with the behavior: _____
_____
_____
_____
_____

Applicant/Responsible Party: _____

Date: _____

Facility Representative: _____

Date: _____

***Please fax back completed form to Ken Bagnis @ (323)227-9032