

Facility:
 Date:
 Surveyor:

Review Form
 Intermediate Care Facility/Individuals with Intellectual Disabilities

Directions: Fill out all information in the appropriate area below.

Name:	Date of Birth:
Admission Date:	Date of Individual Program Plan (IPP):
Guardian:	Phone:

Additional Contacts	Information
Name and Relation Address, Phone	

Childhood Immunizations

Refer to Centers for Disease Control and Prevention (CDC) recommendations:

Immunizations meet recommendations: Yes _____ No _____

If no, documentation from physician: Yes _____ No _____ Not Applicable (N/A) _____

Directions: Fill out the date of each immunization.

Immunization	Date
Tetanus and Diphtheria (at least once every 10 years)	
Tuberculosis (Tb) (upon admission)	
Cholesterol Level (every 3–5 years if within normal limits (WNL))	
Occult Blood Test (annual, start at age 50)	
Flu vaccine (yearly if high risk)	
Pneumococcal vaccine: (one time after age 65, or risk factors exist)	
DEXA Scan (every three years if risk factors exist)	
Zoster (one time after age 60 unless contraindicated)	
[Male] Prostate-Specific Antigen (PSA) (annual, start at age 50)	
[Female] Mammography (baseline 35–40 years of age, annual at age 50)	
[Female] Pap with pelvic exam (every 1–3 years after age 18)	

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Item	Information
Diagnosis	
Allergies	
History and/or Physical	
Dental	
Vision	
Hearing	
Quarterly Pharmacy Reviews	(1) _____ (2) _____ (3) _____ (4) _____
Quarterly Nursing Reviews	(1) _____ (2) _____ (3) _____ (4) _____

IPP Review: In Attendance

Directions: Check-off all those that apply.

Item	<input checked="" type="checkbox"/>
Client	<input type="checkbox"/>
Qualified Intellectual Disabilities Professional (QIDP)	<input type="checkbox"/>
Parent	<input type="checkbox"/>
Home Manager	<input type="checkbox"/>
Speech and Language Pathologist (SLP)	<input type="checkbox"/>
Social Worker	<input type="checkbox"/>
Direct Care Staff	<input type="checkbox"/>
Occupational Therapist (OT) and/or Physical Therapist (PT)	<input type="checkbox"/>
Guardian	<input type="checkbox"/>
Day Site Staff	<input type="checkbox"/>
Nurse	<input type="checkbox"/>
Dietician	<input type="checkbox"/>
Family Members	<input type="checkbox"/>
Workshop, Job Coach, or Teacher	<input type="checkbox"/>
Administrator	<input type="checkbox"/>
Professional Staff	<input type="checkbox"/>

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Assistive/Mechanical Supports

Directions: Check yes or no if the items listed below are included in the IPP.

Item	Yes <input checked="" type="checkbox"/>	No <input checked="" type="checkbox"/>
Dentures	<input type="checkbox"/>	<input type="checkbox"/>
Glasses	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Aids	<input type="checkbox"/>	<input type="checkbox"/>
Wheelchair	<input type="checkbox"/>	<input type="checkbox"/>
Orthotics	<input type="checkbox"/>	<input type="checkbox"/>
Walker	<input type="checkbox"/>	<input type="checkbox"/>
Cane and/or Gait Belt	<input type="checkbox"/>	<input type="checkbox"/>
Bedrails	<input type="checkbox"/>	<input type="checkbox"/>
Communication Device	<input type="checkbox"/>	<input type="checkbox"/>
Adaptive Eating Equipment	<input type="checkbox"/>	<input type="checkbox"/>

Restrictive Interventions

Directions: Fill out all information as appropriate.

Psychotropic Medication or Other Restrictive Interventions	Start Date	Human Rights Committee (HRC) Consent Date	Guardian Is Consent Informed	Documentation of Less Restrictive measures	Behavior Plan	Replace Behavior	Plan to Reduce Use (W295 & W312) & Tied to Behavior	TD Date	Blood Level Date

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Comprehensive Functional Assessment

Directions: Fill out all information as appropriate.

Evaluation	Date	Recommendations
Dietary		
Occupational Therapy		
Physical Therapy		
Speech		
Social		
Psychological		
Behavioral		
Psychiatric		
Vocational		
Individual Education Plan (IEP) (from school)		
Neurological		
Labs		
Other		
Other		
Other		

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IPP Objectives

Directions: All objectives and training programs must address: frequency (the program is run at 100 percent as defined in the program); technical adequacy (single behavior, measurable); assigned a priority level, a target date, a responsible party; data reflects the objective; progress or regress is monitored; and revisions are made to the IPP as needed. Assessments and IPP must address the following:

Task	<input checked="" type="checkbox"/>	Task	<input checked="" type="checkbox"/>	Task	<input checked="" type="checkbox"/>	Task	<input checked="" type="checkbox"/>
Toileting	<input type="checkbox"/>	Hygiene	<input type="checkbox"/>	Oral care	<input type="checkbox"/>	Eating	<input type="checkbox"/>
Bathing	<input type="checkbox"/>	Dressing	<input type="checkbox"/>	Grooming	<input type="checkbox"/>	Communication	<input type="checkbox"/>
Self-administration of Medication (SAM)	<input type="checkbox"/>	Money management	<input type="checkbox"/>	Community integration	<input type="checkbox"/>	Maladaptive behaviors	<input type="checkbox"/>
Other :	<input type="checkbox"/>	Other:	<input type="checkbox"/>	Other:	<input type="checkbox"/>	Other:	<input type="checkbox"/>

Other Issues: