**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_**

**Benhaven Referral Questionnaire**

**Individual’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Cell Phone # (\_\_\_\_\_\_)\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_**

**Home Phone # (\_\_\_\_\_\_)\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_**

**Email address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Parent/Guardian Name(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Relationship to Individual \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Occupation/Place of work\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Work Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Cell Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Siblings**

**Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ age\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ age\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ age\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ age\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Parents are: Married Divorced Separated**

**Language spoken in the Home\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**In the event of an emergency list 2 people we may contact**

**Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Briefly describe individual’s morning routine:**

**Briefly describe individual’s evening routine:**

**Describe individual’s weekend routine – typical events/activities:**

**List the days of the week and time of day requesting services:**

**Skill Assessment**

**Please indicate how the individual can perform the following activities**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Skill** | **Does independently** | **Does with help** | **Cannot do** | **Comments** |
| **Uses the toilet** |  |  |  |  |
| **Washes hands** |  |  |  |  |
| **Brushes teeth** |  |  |  |  |
| **Shower/bath** |  |  |  |  |
| **Dresses self** |  |  |  |  |
| **Undresses self** |  |  |  |  |
| **Makes a snack** |  |  |  |  |
| **Feeds self** |  |  |  |  |
| **Watches TV** |  |  |  |  |
| **Uses computer/iPad** |  |  |  |  |
| **Listens to music** |  |  |  |  |
| **Understands yes** |  |  |  |  |
| **understands no** |  |  |  |  |
| **speaks** |  |  |  |  |
| **Uses pictures to communicate** |  |  |  |  |
| **Uses sign language** |  |  |  |  |
| **Communicates he/she is sick or hurt** |  |  |  |  |
| **Makes request known** |  |  |  |  |
| **Rides safely in vehicles** |  |  |  |  |
| **Is able to wait for short periods of time** |  |  |  |  |
| **Can occupy free time safely** |  |  |  |  |
| **Can swim** |  |  |  |  |

**Does he/she sleep through the night?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Does he/she have any fears?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Are there any religious restrictions? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Is he/she aggressive? Describe effective response and situations that it is likely to occur.**

**Is he/she self-injurious? Describe effective responses and situations that it is likely to occur.**

**Is he/she destructive? Describe effective responses and situations that it is likely to occur.**

**Are there any safety concerns (e.g. bolting or wandering from home or away from adult, street crossing, hot stoves, water safety, interest in fire)?**

**Are there any other behaviors that is of special concern. For example, unusual sexual behavior (disrobing or masturbating in public, touching others, internet safety concerns)?**

**If so, please describe:**

**Are there any particular eating habits, special diet, or Pica (ingesting non-edible items)? Please describe in specific detail any issues that require special attention:**

|  |  |
| --- | --- |
| **Likes/preferences** | **Dislikes/things that don’t work** |
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**What do you hope for as an achievement at Benhaven?**

**Medical information**

**Physician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Psychiatrist \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Dentist\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Case Manager \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DDS/DSS/DCF/Other (circle one)**

**Does he/she have any allergies? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Does he/she have seizures? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**What type of seizure, describe? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**How often and how long do the typically last? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**List any chronic medical conditions; e.g. asthma, heart issues, GI problems etc.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Medication**

**List any medications taken regularly**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name of medication** | **Why is it prescribed** | **dosage** | **Time of day given** |
|  |  |  |  |
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Rights of Program Participants

*As a participant in Benhaven’s Individual and Family Support Program, you have the following rights:*

* You have the right to services that help you live, work, and play in the most normal way possible
* You have the right to spend your own money on the things that you want and to keep and use your own things
* You have the right to freedom from physical or mental abuse or harm
* You have the right to be treated well with dignity and respect
* You have the right to raise concerns regarding services without ramifications.
* You have the right to access to your personal property
* You have the right to say “NO” to things that will put you in danger
* You have the right to privacy and confidentiality
* You have the right to be free from unnecessary physical restraint

Program Participant’s Name: \_\_\_\_\_\_\_­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Print)

Individual/Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_