I have developmental disability. I think it will help you care for me if you know a little bit about how my disability affects me when I am well. It means there are things I can do, things I need help with, and things I cannot do. Please place this information in my chart so that it may help everyone who will care for me while I am here. Thank you.

Date________ My name is ____________________ I like to be called________________________ Room #_______

Person with me is ______________________________ Contact: ____________________________________________

Person making my medical decisions today is ______________________ Contact: ________________________________

My regular Dr. is ______________________ Contact: _________________________________________________

I have these allergies:________________________________ My triggers/sensitivities are: ____________________________

I am here because:

☐ I hurt myself  How? When?
☐ I am in pain ☐ Sharp  ☐ Ache  Where?
☐ I am sick  How long?
☐ I am short of breath  ☐ I have chest pains ☐ I passed out
☐ I keep throwing up  ☐ I have diarrhea/cramps
☐ I have a bad ☐ cough ☐ sore throat ☐ earache
☐ I had a seizure  It lasted____ minutes  Other

I usually treat the issue by

I am currently being treated for:

☐ High blood pressure ☐ Heart problems ☐ Diabetes ☐ Cancer
☐ Bladder infection ☐ Lung/breathing problem ☐ Stomach ☐ Arthritis
☐ Seizure disorder ☐ Thyroid ☐ Other

What you should know about me and how my disability affects me:

Physically:

☐ I can push the call button ☐ I cannot push the call button
☐ I walk unaided ☐ I walk slowly ☐ I use a walker ☐ I use a wheelchair

Other
With help I can:

- Do my personal cares
- Get in and out of bed
- Go to the bathroom
- Feed myself
- Take medication

I will need to be:

- Lifted in and out of bed
- Fed
- Bathed
- Toileted
- Given medication
- Other

Communication:

- I can speak for myself, please try to listen
- I cannot speak for myself
- I am deaf/hard of hearing
- I have an interpreter

<table>
<thead>
<tr>
<th>I can communicate through:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Computer</td>
</tr>
<tr>
<td>Gestures/facial expressions</td>
</tr>
<tr>
<td>Sign language</td>
</tr>
<tr>
<td>Pictures</td>
</tr>
<tr>
<td>I can write things down</td>
</tr>
</tbody>
</table>

Understanding:

- I can understand what you say to me
- I like simple terms and step by step directions
- I may not understand what you say to me

Special concerns and/or fears:

When I am anxious or frustrated it helps me feel better if I have: ____________________________________________

- It is hard for me to sit still

- I am fearful of: Medical exams Being touched Shots Other ________________________________

Please tell me before you do any of these things (list):

<table>
<thead>
<tr>
<th>People in my life:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relationship</td>
</tr>
<tr>
<td>Family Member:</td>
</tr>
<tr>
<td>Guardian:</td>
</tr>
<tr>
<td>Attendant:</td>
</tr>
<tr>
<td>Support Person:</td>
</tr>
<tr>
<td>Home Health:</td>
</tr>
</tbody>
</table>

Medical decisions, Advanced Directive, and/or Power of Attorney information:

__________________________________________________________________________________________