

Living Resource Record

Name: _____ DOB _____

Address: _____

Do you have a guardian/medical surrogate? Yes No Name of guardian _____

Diagnoses: _____

Unique Communication/Cultural needs _____

Assistive Technology _____

Insurance Co./Policy #: _____

Case Mgr: _____

Phone: _____

In Case of Emergency Call:

Name: _____ Relationship: _____

Address: _____

Phone: _____

Representative Payee: _____

Type of SS or income: _____

Family Doctor:

Name: _____ Phone: _____

Address: _____

Dentist

Name: _____ Phone: _____

Address: _____

Hospital in Case of Emergency:

Name: _____ Phone: _____

Address: _____

Form of ID: Drivers' License ID Card

Location of Important Documents: (SS#, birth certificate, court papers, insurance information, banking information)

Name: _____ Phone: _____

Address: _____

Specialists:

For: _____

Name: _____ Phone: _____

Address: _____

For: _____

Name: _____ Phone: _____

Address: _____

Other Case Manager/Care Coordinator/professional helpers:

Name: _____ Phone: _____

Address: _____

Immunization/Dates:

DPT/TD: _____ Chicken Pox: _____

Polio: _____ TB: _____

MMR: _____ Flu: _____

Hep B: _____ Pneumonia: _____

HIB: _____ Other: _____

Equipment:

Type: _____

Name: _____ Phone: _____

Address: _____

Type: _____

Name: _____

Vendor: _____ Phone: _____

Allergies: _____

Blood Type: _____

Medications-current: _____

Past Medications with any reaction: _____

Surgeries/Treatments/Hospitalizations: _____

Follow-up Recommended: _____

Dietary Nutritional needs: _____

Pharmacy:

Name: _____ Phone: _____

Address: _____

Medical Alerts:

Do you have specific protocols? Yes No If so, please attach.

| Special Evaluations: | Date | Place | Copy Available | |
|--|------|-------|----------------|----|
| | | | Yes | No |
| IQ Test | | | | |
| Hearing Test | | | | |
| Vision | | | | |
| Dr. statement/ report of disability | | | | |
| Psychological | | | | |
| Mental Health | | | | |
| Learning Disability | | | | |
| Other | | | | |

Develop/Social History:

Milestones: _____

Educational Level Reached: _____

Names of Teacher/Specialist: _____

Copy of most recent IEP: _____ School Transcripts: _____

Names of Schools and Addresses: _____

Family History: _____

Contacts with knowledge of client: (past and present, social service person)

Name: _____ Phone: _____

Address: _____

Current community supports: (people who help you)

Current Special Needs Trust: Yes No

Special Awards: (diploma, certificates, etc.)

Other Information: _____

Employment / Volunteer History: (last 3)

1. Employer Name: _____ Phone: _____
Address: _____
Job Title/Duties: _____
Dates: From _____ to _____
Name of Supervisor: _____
Accommodations needed: _____

Employment / Volunteer History: (last 3)

2. Employer Name: _____ Phone: _____
Address: _____
Job Title/Duties: _____
Dates: From _____ to _____
Name of Supervisor: _____
Accommodations needed: _____

Employment / Volunteer History: (last 3)

3. Employer Name: _____ Phone: _____
Address: _____
Job Title/Duties: _____
Dates: From _____ to _____
Name of Supervisor: _____
Accommodations needed: _____