Facility Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Individual Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Living Unit (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Completed By:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Important Things to know about the individual (likes/dislikes/routine, etc.)**

1. **Behavior Supports:** (Describe any pertinent information about the individual’s behaviors):
2. **Medical/Healthcare:** (Describe any diagnoses of significant concern, allergies, specific treatments, side effects, system of medication administration, etc.):
3. **Personal Care:** (Describe any pertinent information regarding personal care, including personal care, incontinence care, etc.)
4. **Dietary:** (Describe any issues with meals, special dietary restrictions, allergies, food consistency, choking risks, etc.)
5. **Friends/Family** (Describe pertinent information related to family/friends)
6. **Mobility/Adaptive Equipment** (Describe use of adaptive equipment, safety equipment, history of falls, etc.)
7. **Employment/Active Treatment/Transportation:** (Describe what the person does during the day)