

CONSUMER INFORMATION SUMMARY

Instructions: For designation with box, mark with X

Date _____

CONSUMER NAME _____	<input type="checkbox"/> MALE	<input type="checkbox"/> FEMALE
HOME ADDRESS _____	DATE OF BIRTH _____	_____
ETHNIC ORIGIN _____	TELEPHONE NO. _____	_____
SOC.SEC. NUMBER _____	<input type="checkbox"/> SSI	<input type="checkbox"/> SSA

PHYSICAL DESCRIPTION:

Height _____ Weight _____ Eye Color _____ Hair Color _____

Special physical characteristics _____

PRIMARY DISABILITY _____

SECONDARY DISABILITY _____

MILD MR	MODERATE MR	SEVERE MR	PROFOUND MR
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FULL SCALE I.Q. _____

REHABILITATION NEEDS _____

PRIOR SERVICES:

Work Experience	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Public School	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Community Living Skills	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Institutionalized	<input type="checkbox"/> Yes	<input type="checkbox"/> No

CURRENT SERVICES:

<input type="checkbox"/> WORK SERVICES-FACILITY _____	<input type="checkbox"/> WORK SERVICES - COMBINED
<input type="checkbox"/> WORK SERVICES-SUPPORTED EMPLOYMENT _____	<input type="checkbox"/> WORK SERVICES - PRIVATE PAY
<input type="checkbox"/> DD GROUP HOME _____	<input type="checkbox"/> TRANSPORTATION
<input type="checkbox"/> SUPPORTED LIVING _____	

DATE ENTERED SERVICES: _____ DATE DISCHARGED: _____

CASE MANAGER: _____

PRIMARY HEALTHCARE PROVIDERS:

	Name	Phone No.
MEDICAL DOCTOR	_____	_____
DENTIST	_____	_____
PSYCHOLOGIST	_____	_____
OTHER	_____	_____

MEDICATIONS _____ TYPE AND DOSAGE (N/A if none) _____

HEALTH STATUS/RESTRICTIONS _____

ALLERGIES AND/OR SPECIAL DIETARY NEEDS _____

MEDICAID MEDICARE OTHER INSURANCE CO. _____

GUARDIAN:

<input type="checkbox"/> Self	Relationship (mother, sister, etc.): _____
<input type="checkbox"/> Other: Name _____	
Address _____	Ph. No. _____

PARENT OR FAMILY MEMBER:

Relationship (mother, sister, etc.) _____	No Contact
Name _____	Ph. No. _____
Address _____	

SPECIAL FRIEND OR ADVOCATE:

Name _____	Ph. No. _____
Address _____	

EMERGENCY CONTACT:

Name _____	Ph. No. _____
Address _____	

