

Staff: \_\_\_\_\_



Service Recipient: Shawn Orloske

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

Service Span: \_\_\_\_\_

Is this person able to self-manage according to the IAPP, SMA & Support Plan Addendum – check yes or no below

<p><b>Allergies:</b>  <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A</p>	<p>List &amp; Describe Supports: Corticosteroids, cashews, latex, Pediazole (combination of Erythromycin and Sulfisoxazole)                  Staff ensure Shawn receives only physician ordered medications and follow no latex signs                  Medication Allergies? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes                  *Listed on MAR, only administer meds per dr. order*</p>
<p><b>Seizures:</b>  <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A</p>	<p>Describe Supports: Diagnosed with epilepsy and takes daily medication at home. Seizure disorder considered partially controlled. Seizures range from momentary fluttering eyes to absence seizures and tonic clonic. Increase of seizures when tired or mealtimes. Staff will monitor for seizure activity and report all seizures to guardian within 24hrs.</p>
<p><b>Choking/ Specialized Diet:</b>  <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>Describe Supports: Pureed diet to prevent choking. Pockets food in mouth/cheeks. History of falling asleep and having seizures while eating. Fed by staff using regular spoon, offered drinks from regular cup, and encouraged to eat slowly.</p>
<p><b>Chronic Medical Conditions:</b>  <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A</p>	<p>List &amp; Describe Supports: Epilepsy, Cerebral Palsy, Hypotonia, Macrocephaly, Intellectual Disability, Scoliosis, Spastic Quadriplegia, Skin integrity, spinal fusion, hip dysplasia/potential nerve damage                  -Staff assist in managing Shawn's chronic medical conditions and report any concerns to Shawn's guardian. Staff ensure they are trained to Shawn and his needs prior to working with him.                  DNR/DNI? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes                  *Located in main file, share with EMT in emergency*</p>
<p><b>Medication:</b>  <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>Describe Supports: PRN medications orally in soft foods such as pudding or apple sauce followed by a sip of water                  Daily medication at PAI? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes                  *A trained staff will administer meds per a signed dr. order*</p>
<p><b>Personal Cares:</b>  <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>Describe Supports: Disposable brief- assisted in changing every 2 hours and as needed. Transferred using a hoier lift or in ceiling track system with a split leg sling with a hood to support his neck. In an emergency, Shawn may also be transferred reverse basket by two staff.</p>
<p><b>Mobility/Fall Risk:</b>  <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>Describe Supports: Medical conditions put him at high risk of falling and impact mobility. Shawn can not bear weight. Uses tilt wheelchair and is provided total physical assistance to maneuver chair. Staff visually check him to ensure that both his seatbelt and pelvic straps are fastened, both ankle straps are on, and his chest strap.</p>
<p><b>Community Support:</b>  <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>Describe Supports: 1:1 in the community  <input checked="" type="checkbox"/> Staff will model pedestrian &amp; stranger safety, provide transportation in the community, &amp; provide supervision to meet health &amp; safety needs</p>
<p><b>Sensory Support:</b>  <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A</p>	<p>List &amp; Describe Supports: Overstimulation – Does not like loud environments                  -Staff offer a fan or cool cloth and is encouraged to communicate using his picture board and yes/no board</p>

Lead Review Completed: \_\_\_\_\_

Staff: Colette Rice  
 Date: 1.25.23



Service Recipient: Shawn Orloske  
 Service Span: \_\_\_\_\_

Is this person able to self-manage according to the IAPP, SMA & Support Plan Addendum – check yes or no below

<b>Allergies:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: Corticosteroids, latex, Cashews Pediazole	Medication Allergies? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes <small>*Listed on MAR, only administer meds per dr. order*</small>
<b>Seizures:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	Describe Supports: Seizures range from momentary clonic fluttering eyes to absence seizures tonic	
<b>Choking/ Specialized Diet:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: Pureed diet, Pockets food, regular eat slowly Spoon	
<b>Chronic Medical Conditions:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: Epilepsy, cp, Hypotonia, ID, Scholisis	DNR/DNI? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <small>*Located in main file, share with EMT in emergency*</small>
<b>Medication:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: PRN - orally in soft foods, pudding w/ sip of water	Daily medication at PAI? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <small>*A trained staff will administer meds per a signed dr. order*</small>
<b>Personal Cares:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: Disposable brief, in ceiling track Sling w/ hood to support neck	
<b>Mobility/Fall Risk:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: Cannot bear weight, tilt w/c Emergency Reserve basket	
<b>Community Support:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: 1:1 in community Staff will model pedestrian & stranger safety, provide transportation in the community, & provide supervision to meet health & safety needs	
<b>Sensory Support:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: overstimulation - does not like loud Picture board, yes/no environments board!	
<b>Behavior Support:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: Biting fingers/lips, scratches head.	
Unsupervised time while at PAI? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
Important to: having a towel, soft books, fan, his mom		
Important for: reposition frequently, drink fluids, support w/ 2 people during seizures		
Likes: all activities, painting, sensory, wii, walks		
Dislikes: loud crowded places, music therapy, too warm, loud music		
Communication Style: Body language, facial expressions, vocalizations		
Learning Style: Routine, Repitition		

Lead Review Completed: \_\_\_\_\_

Staff: Kia L. Bauch

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

Service Recipient: Shawn Oploske

Service Span: \_\_\_\_\_

Is this person able to self-manage according to the IAPP, SMA &amp; Support Plan Addendum – check yes or no below

<b>Allergies:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: <u>Corticosteroids, cashew Medication Allergies? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes</u> <u>latex, Pediazole</u> <small>*Listed on MAR, only administer meds per dr. order*</small>
<b>Seizures:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	Describe Supports: <u>diagnosed w/epilepsy + takes medications at home, seizure disorder considered partially controlled</u>
<b>Choking/ Specialized Diet:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Purreeed diet to prevent choking. Pockets food in mouth/ cheeks</u>
<b>Chronic Medical Conditions:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: <u>Epilepsy, Cerebral Palsy, Hypotonia,</u> <small>DNR/DNI? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes *Located in main file, share with EMT in emergency*</small>
<b>Medication:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>PRN medication's orally</u> <small>Daily medication at PAI? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes *A trained staff will administer meds per a signed dr. order*</small>
<b>Personal Cares:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>disposable brief, assisted in changing every 2 hours, in-ceiling track,</u>
<b>Mobility/Fall Risk:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Can not bear weight, tilt wheelchair</u>
<b>Community Support:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>1:1 in the community</u> <input checked="" type="checkbox"/> Staff will model pedestrian & stranger safety, provide transportation in the community, & provide supervision to meet health & safety needs
<b>Sensory Support:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: <u>Overstimulation - does not like loud environment</u>
<b>Behavior Support:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>Self-injurious behaviors, biting nails + lips</u>
Unsupervised time while at PAI? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
Important to: <u>having a towel, soft books, having a fan, his Mom</u>	
Important for: <u>being repositioned, fluids</u>	
Likes: <u>1:1 activities, painting, sensory activities, como zoo outings</u>	
Dislikes: <u>loud or crowded places, music therapy, loud music</u>	
Communication Style: <u>body language, facial expressions, vocalizations</u>	
Learning Style: <u>routine + repetition</u>	

Lead Review Completed: \_\_\_\_\_

Staff: Jill Sales  
 Date: Jan. 25, 2023



Service Recipient: Shawn Orloske  
 Service Span: \_\_\_\_\_

Is this person able to self-manage according to the IAPP, SMA & Support Plan Addendum – check yes or no below

<b>Allergies:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: <u>corticosteroids, cashews, latex + pediazole</u>	Medication Allergies? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes <small>*Listed on MAR, only administer meds per dr. order*</small>
<b>Seizures:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	Describe Supports: <u>Dx. with epilepsy + takes meds @ home. Seizure disorder partially controlled, tonic clonic, fluttering of eyes + absence seizures</u>	
<b>Choking/ Specialized Diet:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>swald diet to prevent choking. Pockets food in mouth cheeks. Hx falling asleep + having seizures while eating</u>	
<b>Chronic Medical Conditions:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: <u>Epilepsy, CP, hypotonia, macrocephaly, IB, scoliosis, spastic Quadriplegia, skin integrity, spinal fusion, hip dysplasia</u>	DNR/DNI? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <small>*Located in main file, share with EMT in emergency*</small>
<b>Medication:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>PRN meds orally in soft foods as pudding or applesauce</u>	Daily medication at PAI? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <small>*A trained staff will administer meds per a signed dr. order*</small>
<b>Personal Cares:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>disposable briefs - change every 2 hours as needed. Transfer using ceiling lift + table.</u>	
<b>Mobility/Fall Risk:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>He cannot bear weight, make sure all straps fastened. High fall risk.</u>	
<b>Community Support:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>1:1 in community</u>	<input checked="" type="checkbox"/> Staff will model pedestrian & stranger safety, provide transportation in the community, & provide supervision to meet health & safety needs
<b>Sensory Support:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: <u>overstimulation - does not like loud environment.</u>	
<b>Behavior Support:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>self injurious behaviors - scratching head, biting fingers + lips</u>	
Unsupervised time while at PAI? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
Important to: <u>having a towel, soft bottles, having his vocalizations recognized + responded to, having a fan, his mom</u>		
Important for: <u>Being repositioned frequently, encourage to drink fluids, being supported by 2 people during seizure to prevent injury</u>		
Likes: <u>1:1 activities, painting, sensory activities, wii, walks outside, socializing w/ his caregivers during task como zoo outings</u>		
Dislikes: <u>loud or crowded places, music therapy, being too warm, loud music</u>		
Communication Style: <u>Body language, facial expressions, vocalizations</u>		
Learning Style: <u>Routine + repetition</u>		

Staff: Ralph Yekal  
 Date: 1-25-2023



Service Recipient: Shawn Orloske  
 Service Span: \_\_\_\_\_

Is this person able to self-manage according to the IAPP, SMA & Support Plan Addendum – check yes or no below

<b>Allergies:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: Corticosteroids, Cashews Latex, Penicillin and Sulfisoxazole. Staff ensure Shawn receives only physician ordered medication	Medication Allergies? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes *Listed on MAR, only administer meds per dr. order*
<b>Seizures:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	Describe Supports: Diagnosed w/epilepsy and takes daily medication at home. Seizure disorder considered partially controlled. Seizures range from momentary fluttering eyes to absence	
<b>Choking/ Specialized Diet:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: Punctured diet to prevent choking. Pockets food in mouth/cheeks. History of falling asleep and having seizures while eating. Fed by staff using regular spoon, offered drinks from regular cup, and encouraged to eat slowly	
<b>Chronic Medical Conditions:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: Epilepsy, Cerebral Palsy, Hypotonia, Macrocephaly, Intellectual Disability, Scoliosis, Spastic Quadriplegia, Skin Integrity, Spinal Fusion, hip dysplasia // Potential nerve	DNR/DNI? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes *Located in main file, share with EMT in emergency*
<b>Medication:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: PRN medication orally in soft foods such as pudding or apple sauce followed by a sip of water	Daily medication at PAI? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes *A trained staff will administer meds per a signed dr. order*
<b>Personal Cares:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: Disposable, brief-assisted in changing every two hours and as needed. Transferred using a hoist lift on in ceiling track system with a split leg sling with a hood to support his neck in an emergency. Shawn may also be transferred basket	
<b>Mobility/Fall Risk:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: medical conditions put him @ high risk of falling and impact mobility. Shawn can not bear weight. Uses tilt wheelchair and is provided total physical assistance to maneuver chair. Staff visually check him to ensure that both his seatbelt and pelvic straps	
<b>Community Support:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: 1:1 in the community	<input checked="" type="checkbox"/> Staff will model pedestrian & stranger safety, provide transportation in the community, & provide supervision to meet health & safety needs
<b>Sensory Support:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: Overstimulation. Does not like hot loud environment. Staff offer a fan or cool cloth and is encouraged to communicate using his picture board and yes/no board.	
<b>Behavior Support:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: SELF-injurious behaviors. scratching head, biting finger and lips, staff encourage Shawn to use his communication board to communicate and will offer him to visit another program area	
<b>Unsupervised time while at PAI?</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
<b>Important to:</b> Having a towel, some books, having his vocalization recognized, and responded to having fun in his room		
<b>Important for:</b> being repositioned frequently, encouraged to drink fluids being supported by two people during a seizure to prevent him from injuring himself		
<b>Likes:</b> activities (painting), sensory activities, wfi, walks outside, socializing with caregivers during tasks, comic books		
<b>Dislikes:</b> loud or crowded places, music, therapy, being too warm, loud music		
<b>Communication Style:</b> body language, facial expression, vocalization		
<b>Learning Style:</b> Routine and repetition		

Staff: Arija S.

Date: 11/15/23



Service Recipient: Shawn Orloske

Service Span: \_\_\_\_\_

Is this person able to self-manage according to the IAPP, SMA & Support Plan Addendum – check yes or no below

<b>Allergies:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: <u>for corticosteroids, cashews, latex, pediazole.</u>	Medication Allergies? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <small>*Listed on MAR, only administer meds per dr. order*</small>
<b>Seizures:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	Describe Supports: <u>Epilepsy and takes daily medication at home. seizures range from momentary eye fluttering to absence seizures and tonic clonic. increase seizures when tired or mealtimes.</u>	
<b>Choking/ Specialized Diet:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>pureed diet to prevent choking. pocket food in mouth/cheeks. history of falling asleep or having seizures while eating, fed by staff using a regular spoon, offered drinks w/ a regular cup, and encouraged to eat slowly.</u>	
<b>Chronic Medical Conditions:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: <u>Epilepsy, cerebral palsy, hypotonia, macrocephaly, intellectual disability, scoliosis, spastic quadriplegia, skin integrity, spinal fusion</u>	Hip dysplasia, DNR/DNI? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <small>Located in main file, share with EMT in emergency*</small>
<b>Medication:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>PRN meds orally in soft foods such as pudding or apple sauce followed by a sip of water.</u>	
<b>Personal Cares:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Disposable brief, assisted in changing every two hours as needed. split sling and in using hoist lift.</u>	
<b>Mobility/Fall Risk:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>medical conditions put him at high risk of falling and impact mobility. Shawn cannot bear weight. uses tilt wheelchair. staff make sure his seat belt and pelvis straps are fastened.</u>	
<b>Community Support:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>1:1 in community</u>	<input checked="" type="checkbox"/> Staff will model pedestrian & stranger safety, provide transportation in the community, & provide supervision to meet health & safety needs
<b>Sensory Support:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: <u>over stimulation - does not like loud environments. staff will offer fan or cool cloth or to communicate with his picture board.</u>	
<b>Behavior Support:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>self-injurious behaviors - <del>over</del> scratching head, biting fingers and lips. staff encourage him to use his communication board and offer to visit another program area</u>	
Unsupervised time while at PAI? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
Important to: <u>Having a towel, soft books, having his vocalizations recognized and responded to, having a fan, his mom</u>		
Important for: <u>being repositioned <del>regularly</del> frequently, encouraged to drink fluids, being supported by two people during a seizure to prevent him from injuring himself.</u>		
Likes: <u>1:1 activities, painting, sensory activities, wii, walks outside, socializing with his caregivers during tasks como zoo, outings, being with family</u>		
Dislikes: <u>loud or crowded places, music therapy, being too warm, loud music</u>		
Communication Style: <u>body language, facial expressions, vocalization</u>		
Learning Style: <u>routine and repetition.</u>		

Staff: Sommer  
 Date: \_\_\_\_\_



Service Recipient: Shawn O  
 Service Span: \_\_\_\_\_

Is this person able to self-manage according to the IAPP, SMA & Support Plan Addendum – check yes or no below

<b>Allergies:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: <span style="float: right;">Medication Allergies? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes        *Listed on MAR, only administer meds per dr. order*</span> Corticosteroids, Cashews, latex, Pediazole
<b>Seizures:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	Describe Supports: Epilepsy, Partially controlled, absence, tonic clonic Increase when tired/meal time
<b>Choking/ Specialized Diet:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: Pureed diet, Pocket Food, history of falling asleep
<b>Chronic Medical Conditions:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: <span style="float: right;">DNR/DNI? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes        *Located in main file, share with EMT in emergency*</span> Epilepsy, CP, Hypotonia, ID, Scoliosis, dysplasia
<b>Medication:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <span style="float: right;">Daily medication at PAI? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes        *A trained staff will administer meds per a signed dr. order*</span> PRN meds, orally in soft foods, w/ water
<b>Personal Cares:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: Bric, change every 2 hours, in ceiling track, Split leg Sling
<b>Mobility/Fall Risk:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: Can not bear weight, need all straps on
<b>Community Support:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <span style="float: right;"><input checked="" type="checkbox"/> Staff will model pedestrian &amp; stranger safety, provide transportation in the community, &amp; provide supervision to meet health &amp; safety needs</span> 1:1 in community
<b>Sensory Support:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: Does not like loud environment, fan / cool cloth, Comm using his picture board
<b>Behavior Support:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: SIB, Scratching head, biting fingers/lips
Unsupervised time while at PAI? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
Important to: having a towel, soft books, mom, his fan	
Important for: drinking, being supported by two people, being w/ family	
Likes: 1:1 activities, painting, wii, walking outside, Como Zoo	
Dislikes: loud/crowded places, music therapy, loud music	
Communication Style: body language vocalization, facial expressions	
Learning Style: Rote/mnemonics	

Staff: ERIN SANDSTROM  
 Date: 1.25.23



Service Recipient: SHAWN ORLOSKE  
 Service Span: \_\_\_\_\_

Is this person able to self-manage according to the IAPP, SMA & Support Plan Addendum – check yes or no below

<b>Allergies:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: CORTICOSTEROIDS, CABTENS, LATEX PEDIAZOLE	Medication Allergies? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes *Listed on MAR, only administer meds per dr. order*
<b>Seizures:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	Describe Supports: EPILEPSY SEIZURES RANGE FROM MOMENTARY FLUTTERING EYES TO ABSENCE SEIZURES & TONIC CLONIC	
<b>Choking/ Specialized Diet:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: PUREED DIET, POCKETS FOOD, REGULAR SPOON, CUP EATS SLOWLY	
<b>Chronic Medical Conditions:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: EPILEPSY, CP, HYPTONIA, MACROCEPHLY ID, SCHIZOSIS	DNR/DNI? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes *Located in main file, share with EMT in emergency*
<b>Medication:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: PRN - ORALLY IN SOFT FOODS - PUDDING W/ SLP OF WATER	Daily medication at PAI? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes *A trained staff will administer meds per a signed dr. order*
<b>Personal Cares:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: DISPOSABLE BRIEF, IN CEILING TRACK SHUTSHIM W/HOOD TO SUPPORT NECK / EMERGENCY - RESERVE BASKET	
<b>Mobility/Fall Risk:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: CANNOT BEAR WEIGHT, HLT W/L	
<b>Community Support:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: 1:1 IN COMMUNITY	<input checked="" type="checkbox"/> Staff will model pedestrian & stranger safety, provide transportation in the community, & provide supervision to meet health & safety needs
<b>Sensory Support:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: OVERSTIMULATION - DOES NOT LIKE LOUD ENVIRONMENTS PICTURE BOARD YES/NO BOARD	
<b>Behavior Support:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: SIB'S, SCRATCHES HEAD, BITING FINGERS/LIPS	
<b>Unsupervised time while at PAI?</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
<b>Important to:</b> HAVING A TOWEL, SOFT BOOKS, FAN, HIS MOM		
<b>Important for:</b> REPOSITIONED FREQUENTLY, DRINK FLUIDS - SUPPORTED W/2 PEOPLE DURING SEIZURE		
<b>Likes:</b> 1:1 ACTIVITIES, PAINTING, SENSORY, WII, WALKS		
<b>Dislikes:</b> LOUD/CROWDED PLACES, MUSIC THERAPY, TOO WARM, LOUD MUSIC		
<b>Communication Style:</b> BODY LANGUAGE, FACIAL EXPRESSIONS, VOWELIZATIONS		
<b>Learning Style:</b> ROUTINE/REPITION		

Lead Review Completed: \_\_\_\_\_

Staff: Jessie K  
 Date: 1/27/23



Service Recipient: Shawn Orlosko  
 Service Span: \_\_\_\_\_

Is this person able to self-manage according to the IAPP, SMA & Support Plan Addendum – check yes or no below

<b>Allergies:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: <u>Corticosteroids, Cough Syrup, Prednisone (combination of Dexamethasone &amp; Self-steroid)</u> Medication Allergies? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes *Listed on MAR, only administer meds per dr. order*
<b>Seizures:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	Describe Supports: <u>Diagnosed with epilepsy &amp; takes 2 pills daily at home. Seizure 1 is side partially convulsions. Seizure 2 is full body convulsions. Seizure 3 is full body convulsions. Rapid response given with seizure.</u>
<b>Choking/ Specialized Diet:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Specialized diet. No dairy food in mouth. Food of food allergy &amp; seizure. While eating, fed by staff using large spoon. Staff drinker to top cup should be encouraged to eat slowly.</u>
<b>Chronic Medical Conditions:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: <u>Epilepsy, CP, Myofascial pain, main body, 1 Dr. scoliosis, specific Quadri. Spinal brace by dysplasia nerve damage</u> DNR/DNI? <input type="checkbox"/> No <input type="checkbox"/> Yes *Located in main file, share with EMT in emergency*
<b>Medication:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>penicillin, used soft foods &amp; as pudding or apple sauce</u> Daily medication at PAI? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes *A trained staff will administer meds per a signed dr. order*
<b>Personal Cares:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Disposable brief, change 2 hours &amp; as needed. Change w/ help with catheter &amp; stool.</u>
<b>Mobility/Fall Risk:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Can't bear weight, MSK full wheelchair &amp; provided full physical assistance</u>
<b>Community Support:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>1/1</u> <input type="checkbox"/> Staff will model pedestrian & stranger safety, provide transportation in the community, & provide supervision to meet health & safety needs
<b>Sensory Support:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: <u>Doesn't like loud environments &amp; off the feet or with cloth to cool body.</u>
<b>Behavior Support:</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	List & Describe Supports: <u>Self injurious behavior, scratching head with fingers &amp; lips.</u>
<b>Unsupervised time while at PAI?</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
<b>Important to:</b> <u>Hand towel, soft brush, hot fan, mom</u>	
<b>Important for:</b> <u>Body repositioned, food &amp; drinks, hot support during seizure</u>	
<b>Likes:</b> <u>1/1 activities, painting, sensory activities, walking, socializing</u>	
<b>Dislikes:</b> <u>Loud or crowded places, music therapy, being too warm, loud music</u>	
<b>Communication Style:</b> <u>Soft language, facial expression, vocalizations</u>	
<b>Learning Style:</b> <u>Reinforce &amp; repetition</u>	

Staff: Deanne Upply  
 Date: 1/26/23



Service Recipient: Shawn Orloske  
 Service Span: \_\_\_\_\_

Is this person able to self-manage according to the IAPP, SMA & Support Plan Addendum – check yes or no below

<b>Allergies:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: <u>Corticosteroid, Carbons</u> <u>Latex, Pedazole</u>	Medication Allergies? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes *Listed on MAR, only administer meds per dr. order*
<b>Seizures:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	Describe Supports: <u>Diagnosed w/ epilepsy + takes daily med. Seizure disorder</u> <u>Part. controlled. Seizures range from momentary flutter eyes to</u> <u>absence seizures + tonic clonic</u>	
<b>Choking/ Specialized Diet:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>pureed diet to prevent choking. Paclets food in mouth</u> <u>History of falling asleep + having seizures while eating</u> <u>Feed on sippy using reg. spoon, drink reg. cup</u>	
<b>Chronic Medical Conditions:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: <u>epilepsy, CP, Hypotonia, megalocphaly</u> <u>DD, scoliosis, spastic quadriplegia, spinal fusion</u>	DNR/DNI? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes *Located in main file, share with EMT in emergency*
<b>Medication:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>PRN med orally in soft</u> <u>food such as pudding or applesauce</u> <u>on top of water</u>	Daily medication at PAI? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes *A trained staff will administer meds per a signed dr. order*
<b>Personal Cares:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Disposal brief - Assisted in changes every 2hrs</u> <u>tsr using hoover lift or in-celling track system</u>	
<b>Mobility/Fall Risk:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>med. conditions put at high risk of falling +</u> <u>impact mobility.</u>	
<b>Community Support:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>1:1 in comm.</u>	<input checked="" type="checkbox"/> Staff will model pedestrian & stranger safety, provide transportation in the community, & provide supervision to meet health & safety needs
<b>Sensory Support:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: <u>Over-stimulation - does not like loud environments</u> <u>offer a fan or cool cloth using his picture board</u>	
<b>Behavior Support:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>Self-injurious behaviors - scratching head</u> <u>biting, hitting fingers + lips</u>	
<b>Unsupervised time while at PAI?</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
<b>Important to:</b> <u>Having a towel, soft books, having his vocalizations</u> <u>recognized + responded to, having a fan, his mom</u>		
<b>Important for:</b> <u>being repositioned frequently, encouraged to drink</u> <u>fluids, being supported by two people during a seizure</u>		
<b>Likes:</b> <u>1:1 activities, painting, sensory activities, wff, walks outside</u> <u>being w/ family</u>		
<b>Dislikes:</b> <u>loud or crowded places, music therapy, being too</u> <u>warm, loud music</u>		
<b>Communication Style:</b> <u>body language, facial expressions, vocalizations</u>		
<b>Learning Style:</b> <u>Routine + repetition</u>		

Staff: Ellie  
 Date: 1-25-23



Service Recipient: Shawn Orloske  
 Service Span: \_\_\_\_\_

Is this person able to self-manage according to the IAPP, SMA & Support Plan Addendum – check yes or no below

<b>Allergies:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: <u>Corticosteroids, cashews, latex</u> Medication Allergies? <input type="checkbox"/> No <input type="checkbox"/> Yes <u>Pedizole</u> Staff will ensure Shawn receives only physician's meds per dr. order* <small>*Listed on MAR, only administer</small>
<b>Seizures:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	Describe Supports: <u>diagnosed with epilepsy and takes meds at home</u> <u>seizure disorder considered partially controlled they range from</u> <u>fluttering eyes to absence seizures and tonic clonic</u>
<b>Choking/ Specialized Diet:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>pureed diet to prevent choking</u> pockets food in mouth/cheek <u>history of falling asleep and having seizures while eating</u> <u>increase of seizures when tired</u>
<b>Chronic Medical Conditions:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: <u>epilepsy, cerebral palsy, hypertonia</u> DNR/DNI? <input type="checkbox"/> No <input type="checkbox"/> Yes <u>intellectual disability, i need damage</u> Staff will ensure <u>Shawn's staff are fully trained</u> <small>*Located in main file, share with EMT in emergency*</small>
<b>Medication:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>PRN medications orally in soft</u> Daily medication at PAI? <input type="checkbox"/> No <input type="checkbox"/> Yes <u>foods such as pudding or applesauce followed by a</u> per a signed dr. order* <small>*A trained staff will administer meds</small>
<b>Personal Cares:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>zip of water</u> <u>Disposable briefs - assisted in changing every 2 hours as needed</u> <u>transfer using a hoist or lift or in ceiling track system with split leg sitting</u> <u>with hand to support his neck</u>
<b>Mobility/Fall Risk:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>medical conditions put him at high risk of falling and</u> <u>impact mobility he can not bear weight uses tilt wheelchair</u> <u>and provides total physical assistance to move</u>
<b>Community Support:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>lil in community</u> <input checked="" type="checkbox"/> Staff will model pedestrian & stranger safety, provide transportation in the community, & provide supervision to meet health & safety needs
<b>Sensory Support:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: <u>over stimulation does not like loud environments</u> <u>staff offer fan or cool cloth encouraged using picture board</u>
<b>Behavior Support:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>Self injurious scratching head biting fingers and lips</u>

Unsupervised time while at PAI?  No  Yes

Important to: having a towel, soft books, having his vocalizing recognized  
and responded to having a fan, his music

Important for: being reassured frequently encouraged to drink fluids being  
supported by a people

Likes: lil activities, sensory activities, and walks outside

Dislikes: loud or crowded places, music therapy

Communication Style: body language facial expressions

Learning Style: routine and repetition

Staff: Natalie Johnson  
 Date: 1-25-2023



Service Recipient: Shawn Orloske  
 Service Span: \_\_\_\_\_

Is this person able to self-manage according to the IAPP, SMA & Support Plan Addendum – check yes or no below

<b>Allergies:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: <u>corticosteroids, castews, latex, pedicole</u>	Medication Allergies? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes *Listed on MAR, only administer meds per dr. order*
<b>Seizures:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	Describe Supports: <u>epilepsy</u>	
<b>Choking/ Specialized Diet:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>pureed diet. pockets food. fed by staff w/ spoon</u>	
<b>Chronic Medical Conditions:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: <u>epilepsy, cerebral palsy, hypotonia, macrocephaly, intellectual disability, spastic quad</u>	DNR/DNI? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes *Located in main file, share with EMT in emergency*
<b>Medication:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>PRN meds orally in soft foods</u>	Daily medication at PAI? <input type="checkbox"/> No <input type="checkbox"/> Yes *A trained staff will administer meds per a signed dr. order*
<b>Personal Cares:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>disposable brief, ment table</u>	
<b>Mobility/Fall Risk:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>shawn cannot bear height staff propel chair</u>	
<b>Community Support:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>lil in community</u>	<input checked="" type="checkbox"/> Staff will model pedestrian & stranger safety, provide transportation in the community, & provide supervision to meet health & safety needs
<b>Sensory Support:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: <u>overstimulation does not like loud environments</u>	
<b>Behavior Support:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>self-injurious behaviors</u>	
<b>Unsupervised time while at PAI?</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
<b>Important to:</b> <u>touch, soft books, having vocalizations recognized</u> <u>mom</u>		
<b>Important for:</b> <u>repositioned, encouraged to drink fluid</u> <u>two people during seizure</u>		
<b>Likes:</b> <u>lil activities, painting, sensory, walks outside</u> <u>socializing</u>		
<b>Dislikes:</b> <u>loud or crowded places, music therapy, being too</u> <u>warm</u>		
<b>Communication Style:</b> <u>body language, facial expressions, vocalizations</u>		
<b>Learning Style:</b> <u>routine and repetition</u>		

Lead Review Completed: \_\_\_\_\_

Staff: Lisa Yang  
 Date: 1/27/23



Service Recipient: Shawn Orloske  
 Service Span: \_\_\_\_\_

Is this person able to self-manage according to the IAPP, SMA & Support Plan Addendum – check yes or no below

<b>Allergies:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: <u>Corticosteroids, Cashew, Latex, Pediazole (Combination of Erythromycin and Sulfisoxazole)</u>	Medication Allergies? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes *Listed on MAR, only administer meds per dr. order*
<b>Seizures:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	Describe Supports: <u>Diagnosed w/ epilepsy &amp; take daily medications at home. Seizure disorder: Seizure momentary fluttering eyes. Absence Seizure. Tonic Clonic. Seizure when tired.</u>	
<b>Choking/ Specialized Diet:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Pureed diet to prevent choking. Pockets food in mouth / Cheeks.</u>	
<b>Chronic Medical Conditions:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: <u>Epilepsy, C.P., Hypotonia, Intellectual Disability, Scoliosis, Spastic Quadriplegia, Skin Integrity, Spinal Fusion, hip dysplasia</u>	Macrocephaly OR/DNI? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes *Located in main file, share with EMT in emergency*
<b>Medication:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>PRN orally in soft foods.</u>	
<b>Personal Cares:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Disposable brief. Changing every 2 hours as needed. Hoyer lift / in ceiling track w/ split leg sling.</u>	
<b>Mobility/Fall Risk:</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	Describe Supports: <u>High risk falling &amp; impact. Can not bear weight. Assist maneuvered chair. Ensure both seat belts &amp; pelvic straps are fastened, Ankle strap are on.</u>	
<b>Community Support:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>1:1 in the community.</u>	
<b>Sensory Support:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: <u>Overstimulation. Do Not like Loud environments. offer fan / cool cloth. Encouraged communication using picture board &amp; yes/no board.</u>	
<b>Behavior Support:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>Scratching head. biting fingers &amp; lips. offer to visit another program.</u>	

Unsupervised time while at PAI?  No  Yes

Important to: Towel, Soft books. Having his vocalizations recognized & responded to. having fan. his mom

Important for: Repositioned frequently. Encouraged to drink fluids. Support by two people during a seizure to prevent injury.

Likes: 1:1 activities, painting, Sensory, wll. walks outside. Socializing w/ his caregivers during tasks. Como Zoo. Family.

Dislikes: Loud or crowded places. Music therapy. Being warm. Loud music.

Communication Style: Body language, Facial expressions, Vocalizations

Learning Style: Routine, Repetition

Staff: Kylla

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



Service Recipient: Shawn

Service Span: \_\_\_\_\_

Is this person able to self-manage according to the IAPP, SMA & Support Plan Addendum – check yes or no below

<b>Allergies:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: Corticosteroids, Cashews, latex Pediazole	Medication Allergies? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes *Listed on MAR, only administer meds per dr. order*
<b>Seizures:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	Describe Supports: Epilepsy + takes meds @ home	
<b>Choking/ Specialized Diet:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: Pureed diet to prevent choking	
<b>Chronic Medical Conditions:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: Epilepsy, Cerebral Palsy, Hypotonia Macrocephaly, Intellectual disability	DNR/DNI? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes *Located in main file, share with EMT in emergency*
<b>Medication:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: PRN med orally in soft foods	Daily medication at PAI? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes *A trained staff will administer meds per a signed dr. order*
<b>Personal Cares:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: Brief, in ceiling track	
<b>Mobility/Fall Risk:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: Medical conditions put @ high risk	
<b>Community Support:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: 1:1	<input checked="" type="checkbox"/> Staff will model pedestrian & stranger safety, provide transportation in the community, & provide supervision to meet health & safety needs
<b>Sensory Support:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: Overstimulation - does not like loud environment	
<b>Behavior Support:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: Self injurious behavior, scratching head, biting fingers & tips	
<b>Unsupervised time while at PAI?</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
<b>Important to:</b> Having a towel, soft books, having a fan, his mom		
<b>Important for:</b> Being repositioned frequently, encouraged to drink fluids being supported by two people		
<b>Likes:</b> 1:1 activities, painting, sensory activities, wii, walks outside socialization w/ his caregivers, como zoo, being w/ family		
<b>Dislikes:</b> Loud or crowded places, music therapy, being too warm loud music		
<b>Communication Style:</b> Body language, facial expressions, vocalization		
<b>Learning Style:</b> Routine & repetition		

Staff: Alex

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



Service Recipient: Shawn O

Service Span: \_\_\_\_\_

Is this person able to self-manage according to the IAPP, SMA & Support Plan Addendum – check yes or no below

<b>Allergies:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: <u>Corticosteroids</u> <u>Cashews, Latex, Prednisone</u>	Medication Allergies? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes <small>*Listed on MAR, only administer meds per dr. order*</small>
<b>Seizures:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	Describe Supports: <u>Epilepsy, daily meds, Seizure disorder</u> <u>Partially controlled, Eye fluttering, Absence Seizures</u> <u>Tonic Clonic</u> Staff will monitor and report	
<b>Choking/ Specialized Diet:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Pureed Diet, pockets food, History of falling up</u> <u>asleep and having seizures while eating fed by staff</u>	
<b>Chronic Medical Conditions:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: <u>Epilepsy, C.P., Hypotonia, Macrocephaly</u> <u>Spatheic Quad, Scoliosis, Spinal Fusion Hip Dysplasia</u>	DNR/DNI? <input type="checkbox"/> No <input type="checkbox"/> Yes <small>*Located in main file, share with EMT in emergency*</small>
<b>Medication:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Orally with soft foods</u> <u>and water</u>	Daily medication at PAI? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <small>*A trained staff will administer meds per a signed dr. order*</small>
<b>Personal Cares:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Disposable Brief changed every 2 hours and as</u> <u>needed w/hygiene Track System. Reverse Bedside</u>	
<b>Mobility/Fall Risk:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Can't bear weight, chest, seat, ankle straps</u>	
<b>Community Support:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Orsted + Sene</u>	<input checked="" type="checkbox"/> Staff will model pedestrian & stranger safety, provide transportation in the community, & provide supervision to meet health & safety needs
<b>Sensory Support:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: <u>Does not like loud environments</u> <u>fan and cool cloth, Use pic board for Yes/No</u>	
<b>Behavior Support:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>Self injurious Behavior, Scratch Head</u> <u>Pile Cans + Lips Offer Room change, pic board</u>	
<b>Unsupervised time while at PAI?</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
<b>Important to:</b> <u>Towel, Soft Bed, Vocalizations understood</u> <u>x Recognized Mom and Mom.</u>		
<b>Important for:</b> <u>Supported, Encourage to Drink fluids</u> <u>Supported during seizure</u>		
<b>Likes:</b> <u>1:1 activities, Painting, sensory, Wii, walks outside</u> <u>Socializing w/ Co-workers, Como Zoo, family</u>		
<b>Dislikes:</b> <u>Music therapy</u> <u>Tow places, Crowds, Loud Music, Tap Worn</u>		
<b>Communication Style:</b> <u>Vocalizations, Body Language Facial Expressions</u>		
<b>Learning Style:</b> <u>Routine + Repeat</u>		

Staff: Maria H

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



Service Recipient: Shawn Orloske

Service Span: \_\_\_\_\_

Is this person able to self-manage according to the IAPP, SMA & Support Plan Addendum – check yes or no below

<b>Allergies:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: <u>corticosteroids, cashews, latex, Pediazole</u> Medication Allergies? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes *Listed on MAR, only administer meds per dr. order*
<b>Seizures:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	Describe Supports: <u>epilepsy take drug med at home seizure disorder seizure range from momentary fluttering eyes to absence seizure and tonic clonic. Maintain and report within 24 hrs</u>
<b>Choking/ Specialized Diet:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>piece of food in mouth, hissing falling asleep and having seizures while eating. fed with reg spoon, reg cup, encourage to eat slow.</u>
<b>Chronic Medical Conditions:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: <u>Epilepsy, cerebral palsy, hypotonia, DNR/DNI, macrocephaly, intellectual disability, scoliosis, spastic quadriplegia. Skin integrity, hip potential nerve</u> *Located in main file, share with EMT in emergency*
<b>Medication:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>PRN 1/2 soft foods such as pudding or apple sauce follow sip a water</u> Daily medication at PAI? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes *A trained staff will administer meds per a signed dr. order*
<b>Personal Cares:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>disposable brief changing every 2 hrs as needed. transferred using hoist lift in ceiling track. Shawn may also be transferred reverse basket by two staff</u>
<b>Mobility/Fall Risk:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Medical conditions put him high risk. Shawn can't bear weight. Uses tilt wheelchair. Staff make sure both hip seat belt pelvic straps are fastened. Both his ankle straps are on and his chest strap</u>
<b>Community Support:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>1 : 1</u> <input checked="" type="checkbox"/> Staff will model pedestrian & stranger safety, provide transportation in the community, & provide supervision to meet health & safety needs
<b>Sensory Support:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: <u>overstimulation - Offer a fan <del>at</del> cloth and is encouraged to communicate using his picture board &amp; Yes/No board.</u>
<b>Behavior Support:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>Self-injurious behaviors - scratching head, biting fingers and lips</u>
<b>Unsupervised time while at PAI?</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
<b>Important to:</b> <u>having a towel, soft books, having vocalizations recognized and responded to, having a fan, his mom</u>	
<b>Important for:</b> <u>being repositioned frequently, encourage to drink fluids, being supported by two people during seizure</u>	
<b>Likes:</b> <u>activities, painting, sensory activities, vll, walks outside, socializing with his caregivers during tasks, como zoo activities, being with family.</u>	
<b>Dislikes:</b> <u>loud or crowded places, music therapy, being too warm, loud music</u>	
<b>Communication Style:</b> <u>body language, facial expressions, vocalizations</u>	
<b>Learning Style:</b> <u>Routine and Repetition.</u>	

Staff: Laura Stacken  
 Date: 1/25/2023



Service Recipient: Shawn Orloske  
 Service Span: \_\_\_\_\_

Is this person able to self-manage according to the IAPP, SMA & Support Plan Addendum – check yes or no below

<b>Allergies:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: <u>corticosteroids, cashews, Latex, Peditazole (combination of erythromycin &amp; sulfisoxazole)</u> Medication Allergies? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes <small>*Listed on MAR, only administer meds per dr. order*</small>
<b>Seizures:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	Describe Supports: <u>Diagnosed w/ epilepsy &amp; takes daily medication at home. Seizure disorder considered partially controlled.</u>
<b>Choking/ Specialized Diet:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Pureed diet to prevent choking, pockets food in mouth/cheeks. History of falling asleep &amp; having seizures while eating. Fed by staff using reg. Spoon offered drinks from reg cup.</u>
<b>Chronic Medical Conditions:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: <u>Epilepsy, cp, hypotonia, macrocephaly, ID, scoliosis, Spastic quad, skin integrity, spinal fusion, hip dysplasia/potential nerve</u> DNR/DNI? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <small>*Located in main file, share with EMT in emergency*</small>
<b>Medication:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>PRN med orally in soft foods pudding/applesauce.</u> Daily medication at PAI? <input type="checkbox"/> No <input type="checkbox"/> Yes <small>*A trained staff will administer meds per a signed dr. order*</small>
<b>Personal Cares:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Brief - assisted in changing every 2 hours &amp; as needed.</u>
<b>Mobility/Fall Risk:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Medical conditions put him at high risk of falling &amp; impact mobility - Shawn</u>
<b>Community Support:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>1 in community</u> <input checked="" type="checkbox"/> Staff will model pedestrian & stranger safety, provide transportation in the community, & provide supervision to meet health & safety needs
<b>Sensory Support:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: <u>overstimulation does not like loud environment.</u>
<b>Behavior Support:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>Self-injurious behaviors - scratching head, biting fingers and lips</u>
<b>Unsupervised time while at PAI?</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
<b>Important to:</b> <u>Having a towel, soft books, having his vocalization recognized &amp; responded to, having a fan, his mom</u>	
<b>Important for:</b> <u>repositioned frequently, encouraged to drink fluids, being supported by two people during a seizure.</u>	
<b>Likes:</b> <u>1:1 activities, painting, sensory activities, wii, walks outside, socializing with his caregivers during tasks, Como Zoo, outings, being with his family</u>	
<b>Dislikes:</b> <u>loud or crowded places, music therapy, being too warm</u> <u>loud music</u>	
<b>Communication Style:</b> <u>body lang, facial expression, vocalizations</u>	
<b>Learning Style:</b> <u>Routine &amp; repetition</u>	