Today's Date: _____

UI should be faxed to:
_____
Fax Number: _____

4607 Cleveland Ave. NW
Canton, Ohio 44709
330-455-8111

2021 Social History Form

INCLUDE A COPY OF YOUR PHOTO ID WITH THIS FORM

Participant Information:

Legal Name (as it appears on your State ID): _____

Preferred Name (if different from legal name): _____

Home Address: _____City:_____

State: ____ County: _____ Zip: _____ Phone: ( ) _____

Agency Name: _____

Agency Address (if different than above)_____ City:_____ State: ____

County:_____ Zip: _____ Phone: ( )_____

Where do you prefer we send trip info (please check one)? ☐ Home ☐ Provider

Type of living situation (check):

☐ Family ☐ Group Home ☐ Apartment ☐ Independent Living

Age: _____ Birthdate: _____/_____/_____ Gender: _____

Height: _____ Weight: _____ Marital Status: _____

Eye Color: _____ Hair Color: _____ Race: _____

Any distinguishing features: _____

Contacts, Glasses, Hearing Aids, Other Adaptive Equipment: _____

Primary Diagnosis: _____

Secondary Diagnosis: _____

Is Participant fully ambulatory? Yes ☐ No ☐

Does applicant walk at slow pace or unsteady gait? Yes ☐ No ☐

Indicate mobility assistance needed: _____

Is participant able to swim? Yes ☐ No ☐

Please specify any water related issues here:_____

Is participant visually impaired? Yes ☐ No ☐

If yes please describe: _____

Is participant hearing impaired? Yes ☐ No ☐

Describe any sign language used? _____

Is participant understandable when speaking? Yes ☐ No ☐

If not, explain communication system: _____

How does individual make needs known? _____

Does the participant have a current passport? Yes ☐ No ☐ If Yes: expiration date:_____

Continued→

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Medical Information:

*The following information is required by our R.N.

A copy of the current medication administration record (MAR) MUST be submitted to Beyond Our Boundaries prior to leaving on a trip.

MEDICATIONS

Medication Administration:

☐ Self- Administering WITHOUT assistance
☐ Self- Administering WITH assistance (please identify what assistance is needed):

_____

☐ Individual requires Staff to administer medications
- ✓ Please provide a current Self-Medication Assessment

Packaging Medications

All staff-administered medications must be packaged by the pharmacy in single dose, labeled packaging such as PillPack, Doc-U-Dose or your pharmacy's equivalent. These must be dropped off at our office the day before departure to be placed in a locked cabinet. (On Friday for Sunday or Monday departure),

Current List of Medications

Please include prescription medications, over the counter medications, and PRN (as needed) medications.

Med Name ---------- Dose ------- Route -------- Time -------Special Directions

✓ _____

✓ _____

✓ _____

✓ _____

✓ _____

✓ _____

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PRN (as needed) Medications

Med Name ---------- Dose ------- Route -------- Time -------Special Directions

✓ _____

✓ _____

✓ _____

✓ _____

Date of Last Flu Shot: _____

Date of Last Pneumonia Shot: _____

Has participant received the COVID-19 vaccine? Yes ☐ No ☐

Date of 1st shot_____

Date of 2nd shot_____

Is participant compliant with wearing a face mask or face shield? Yes ☐ No ☐

Allergies? Yes ☐ No ☐ If yes, is an Epi-Pen prescribed? Yes ☐ No ☐

If yes please specify (include insect bites, food, etc. and reaction):

_____

_____

Special Diet? Yes ☐ No ☐

Describe: _____

Dietary Restrictions? Yes ☐ No ☐

Describe: _____

Individual is at risk for aspirating? Yes ☐ No ☐

Activity Restrictions? Yes ☐ No ☐

Describe: _____

Bowel or Incontinence issues? Yes ☐ No ☐

Explain: _____

Medications prescribed for constipation: _____

Medications prescribed for diarrhea: _____

_____

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Diabetic? Yes ☐ No ☐

Blood sugar testing? Please list times of day: _____

Independent testing blood sugar? Yes ☐ Needs assistance ☐

Parameters for blood sugar: _____

Seizure disorder? Yes ☐ No ☐

Describe a typical seizure: _____

_____

Date of most recent seizure: _____

Order for Diastat? Yes ☐ No ☐

Individual has a Vagus Nerve Stimulator? Yes ☐ No ☐

Physician's order for seizure parameter/protocol: _____

_____

Metal implants such as hip/knee replacements or pace makers? Yes ☐ No ☐

Describe type and location: _____

_____

Please note or attach any other relevant medical information about the participant.

_____
_____
_____
_____
_____
_____
_____
_____

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Emergency Information:

Legal Guardian: _____ Phone: ( ) _____

Relationship to Participant: _____

BEYOND OUR BOUNDARIES MUST BE NOTIFIED OF ANY CHANGES IN GUARDIANSHIP

Contact 1: _____ Phone: ( ) _____

Relationship to Participant: _____

Contact 2: _____ Phone: ( ) _____

Relationship to Participant: _____

SSA: _____ Phone: ( ) _____

Email:_____

(This is the person from the county board of DD who coordinates all of your services)

Payee: _____ Phone: ( ) _____

Primary Care Physician: _____

Phone: ( ) _____

Preferred Hospital: _____ Phone: ( ) _____

Dentist: _____ Phone: ( ) _____

Other Medical Professionals:

Name: _____ Phone: _____

Specialty: _____

Pharmacy used: _____

Phone: ( ) _____

Continued→

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Social/Behavioral: (if not marked yes please explain)

Does participant interact appropriately with: Staff Yes ☐ No ☐
Explain: _____
_____

Does participant interact appropriately with: Peers Yes ☐ No ☐
Explain: _____
_____

Does participant interact appropriately with: Strangers Yes ☐ No ☐
Explain: _____
_____

Is he/she capable of safely and respectfully sharing a hotel room with another participant?
Yes ☐ No ☐ If no, please explain:
_____
_____

Does he/she understand how to stay with their chaperone and a group?
Yes ☐ No ☐ If no, please explain:
_____
_____

Does participant smoke? Yes ☐ No ☐

Check those that apply and explain below if necessary:

- ☐ Talkative
- ☐ Has history of stealing/ may steal
- ☐ Fabricates stories
- ☐ Shy/ withdraw/ keeps to self
- ☐ Is cooperative
- ☐ Follows directions
- ☐ Makes choices
- ☐ Needs coaxing to join activities
- ☐ Talks to strangers
- ☐ Wanders (explain)
- ☐ Teases others
- ☐ Helpful/kind to others
- ☐ Enjoys socialization

Please explain or add any behaviors not covered. *If participant is on a behavior plan please attach*: _____
_____
_____

Continued→

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Activities of Daily Living: Please check and provide details as needed

Self-Care Skills	Totally Independent	Needs Assistance	Poor	Specify Support Required
Dressing	☐	☐	☐	
Bathing	☐	☐	☐	
Toileting	☐	☐	☐	
Hygiene	☐	☐	☐	
Feeding	☐	☐	☐	
Skills				
Money	☐	☐	☐	
Reading	☐	☐	☐	
Writing	☐	☐	☐	
Telling time	☐	☐	☐	

Please provide any further information if participant is not <u>totally independent</u> that will assist us in making sure that we provide the services that your participant needs.

_____

_____

_____

_____

_____

BEYOND OUR BOUNDARIES MUST BE NOTIFIED OF ANY SIGNIFICANT CHANGES IN ABILITIES AND/OR CARE NEEDS OF THE PARTICIPANT

Name of Person Filling this out: _____

Relation to Participant: _____ Phone: ( ) _____