CONSUMER INFORMATION & EMERGENCY CONTACT INFORMATION

CONSUMER INFORMATION		
Consumer Name:	Date of Birth:	Living Status: ☐ Independent ☐ Adult Residential Home ☐ Family
Home Address:		Home:

Residential Care Provider Name	Behavioral Level of Home	RSP Telephone	Administrators Cell Phone
CVRC Counselor	**CVRC Counselor Telephone**	**Date of Last T.B. Test**	**T.B. Results (Negative or Positive)**
Physician(s):	**Physician's Phone Number:**	**Pharmacy:**	**Pharmacy's Phone Number:**

EMERGENCY CONTACTS				
NAME	RELATIONSHIP	HOME PHONE	MOBILE PHONE	WORK PHONE

MEDICAL CONDITIONS (List all)		
1.	2.	3.
4.	5.	6.

LIST ALL KNOWN BEHAVIORS (EVEN IF NOT LISTED ON IPP) DOES CONSUMER AWOL? ☐ YES ☐ NO		
1.	2.	3.
4.	5.	6.
7.	8.	9.

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ALLERGIES TO MEDICATIONS? ☐ YES ☐ NO (IF YES PLEASE LIST BELOW)	
NAME OF MEDICATION	TYPE OF REACTION

ALLERGIES TO FOOD? ☐ YES ☐ NO (IF YES PLEASE LIST BELOW)	
NAME OF FOOD	TYPE OF REACTION

SPECIAL DIET OR FOOD RESTRICTIONS? ☐ YES ☐ NO (IF YES PLEASE LIST BELOW)	

CURRENT MEDICATION REGIMEN (TAKEN) INCLUDE ALL PRN'S			
MEDICATION	DOSAGE	FREQUENCY	CONDITION / SPECIAL NOTES