

NURSING CARE FOR THE DEVELOPMENTALLY DISABLED PERSON – CLINICAL

MENT 72 L CLINICAL ASSIGNMENT PACKET

- ✓ All work is to be done in **black** ink
 - Errors must be noted appropriately
 - No eraser fluids or tape may be used
- ✓ Writing must be legible
- ✓ Failure to turn in assignments on time will result in probation and may lead to failure of meeting necessary objectives
- ✓ Any missing/uncorrected assignments will result in a 'No Pass' grade for clinical. It is the student's responsibility to keep track of their assignments.
- ✓ Extra packets and copies of individual assignments will not be supplied
- ✓ Assignments will be returned for:
 - < 75% accuracy
 - Spelling / grammatical errors
 - Neatness
- ✓ Corrections are due the next clinical day unless otherwise stated by your instructor. Failure to submit clinical assignment will result in an attempt (x2...) for each day corrections are late.
- ✓ All work submitted must be YOUR OWN ORIGINAL WORK. You may not rewrite any examples or templates provided in class.

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Student Name: _____

Clinical Instructor: _____

LINCOLN / COVINA P. 7-33

☐	☐	☐	☐	Documentation
☐	☐	☐	☐	Positive Behavior Support Plan
☐	☐	☐	☐	Motivation Assessment Scale
☐	☐	☐	☐	ABC Data Sheet
☐	☐	☐	☐	Scatter Plot
☐	☐	☐	☐	Behavior Map
☐	☐	☐	☐	Intellectual & Adaptive Skills
☐	☐	☐	☐	Task Analysis
☐	☐	☐	☐	Pharmacology Math Practice

OPARC - DI or PVW P. 35-57

☐	☐	☐	☐	Documentation
☐	☐	☐	☐	Training Plan
☐	☐	☐	☐	Tally Sheet
☐	☐	☐	☐	Intellectual & Adaptive Skills
☐	☐	☐	☐	Task Analysis
☐	☐	☐	☐	Making Measurable Objectives
☐	☐	☐	☐	Self-Assessment for PVW

Functionally Equivalent Behaviors

☐	Week 3 (p.139)
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Self-Administration of Meds

P. 143-145

☐	Week 7
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Seizure Assignment P. 149

☐	Week 8
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Alternate Assignments (as needed)

☐
☐
☐
☐

CASA COLINA P. 59-101

☐	☐	☐	☐	Documentation
☐	☐	☐	☐	Weekly Journal
☐	☐	☐	☐	Weekly Assessment of Progress
☐	☐	☐	☐	Training Plan
☐	☐	☐	☐	Group Leadership
☐	☐	☐	☐	Task Analysis
☐	☐	☐	☐	Intellectual & Adaptive Skills
☐	☐	☐	☐	Chart Assignment
☐	☐	☐	☐	Medication Administration

OPARC – ADC / SS P. 103-135

☐	☐	☐	☐	Documentation
☐	☐	☐	☐	Functional Communication Plan
☐	☐	☐	☐	Communication Questionnaire
☐	☐	☐	☐	Positive Environmental Checklist
☐	☐	☐	☐	Reinforcement Inventory
☐	☐	☐	☐	Communication Assessment Tool
☐	☐	☐	☐	Intellectual & Adaptive Skills
☐	☐	☐	☐	Pharmacology Math Practice

Sensory Motor Assignment

P. 153

☐	Week 9
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Lifespan Plan P. 157

☐	Week 12
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Sexuality Plan P. 161-163

☐	Week 14
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DOCUMENTATION EXAMPLES

The “ABCs” of Documentation

- APPEARANCE – What you see
 - Well groomed, disheveled, unkempt, dresses appropriately, odor, tattoos, piercings, steady gait, uses wheel chair...
- BEHAVIOR - What they do (be descriptive)
 - Fidgety, does not sit still, does not respond to name, bright affect, smiles, appropriate eye contact....
- COMMUNICATION / CONVERSATION – What they say & how they say it
 - Write EXACTLY what they said using “ ” (subjective statements)
 - Rapid speech, slow speech, clear, audible, mumbling, voice appropriate for situation....

* Remember, Pronouns are not needed in the documentation. Your note should be clear and concise, yet still descriptive.

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The following pages are to be completed at:

Lincoln Elementary School

And

Covina Education Center

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MENT 72L

Submit upon completion

Name:

Date:

Documentation

Document an interaction you have had with a consumer. Use a narrative format to identify consumer's physical status, participation in treatment or work, and methods of communication. Remember to document the consumer's appearance, behaviors, and communication skills.

Date	Time	All entries are to be signed with name and title

Faculty comments:

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Name: _____

Positive Behavior Support Plan

A –

1st level assessment –

2nd level assessment – list the results from the following assessments

MAS -

Scatter plot-

ABC -

Behavior map -

Baseline (what, where, when, with whom):

P – (operationalized goal):

Milestone 1:

Milestone 2:

Milestone 3:

I –

Reinforcers

- 1.
- 2.
- 3.

Reinforcement schedule -

Prompts (must match level of restrictiveness given in operationalized goal)

- 1.
- 2.
- 3.

E –

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MOTIVATION ASSESSMENT SCALE

Name _____

Date _____

Behavior Description:

Instructions: It is very important that you identify the target behavior very specifically. "Aggressive" is not as good a description as "hits peer." Once you have specified the behavior to be rated, read each question carefully and circle the one number which best describes your observation of this behavior.

1. Would this behavior occur continuously if the student were left completely alone for long periods of time? (e.g., 3 hours. Note: alone means completely alone without anyone around or nearby).

Never	Almost Never	Seldom	Half the Time	Usually	Almost Always	Always
0	1	2	3	4	5	6

2. Does this behavior occur following a request to perform a difficult task?

Never	Almost Never	Seldom	Half the Time	Usually	Almost Always	Always
0	1	2	3	4	5	6

3. Does this behavior occur when you are talking to other persons in the room?

Never	Almost Never	Seldom	Half the Time	Usually	Almost Always	Always
0	1	2	3	4	5	6

4. Does this behavior ever occur to get a toy, food or game that he/she has been told that he/she can't have?

Never	Almost Never	Seldom	Half the Time	Usually	Almost Always	Always
0	1	2	3	4	5	6

5. Does this behavior occur repeatedly, over and over, in the same way? (Example: rocking back and forth for five minutes).

Never	Almost Never	Seldom	Half the Time	Usually	Almost Always	Always
0	1	2	3	4	5	6

6. Does this behavior occur when any request is made of the student?

Never	Almost Never	Seldom	Half the Time	Usually	Almost Always	Always
0	1	2	3	4	5	6

7. Does this behavior occur whenever you stop attending to him/her?

Never	Almost Never	Seldom	Half the Time	Usually	Almost Always	Always
0	1	2	3	4	5	6

8. Does this behavior occur when you take away a favorite toy or food?

Never	Almost Never	Seldom	Half the Time	Usually	Almost Always	Always
0	1	2	3	4	5	6

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9. Does it appear to you that he/she enjoys performing this behavior, and would continue even if no one were around?

Never	Almost Never	Seldom	Half the Time	Usually	Almost Always	Always
0	1	2	3	4	5	6

10. Does the student seem to do this behavior to upset or annoy you when you are trying to get him/her to do what you ask?

Never	Almost Never	Seldom	Half the Time	Usually	Almost Always	Always
0	1	2	3	4	5	6

11. Does the student seem to do this behavior to upset or annoy you when you are not paying attention to him/her? (Example: sitting in a separate room, interacting with another child.)

Never	Almost Never	Seldom	Half the Time	Usually	Almost Always	Always
0	1	2	3	4	5	6

12. Does this behavior stop occurring shortly after you give the toy or food he/she has requested?

Never	Almost Never	Seldom	Half the Time	Usually	Almost Always	Always
0	1	2	3	4	5	6

13. When this behavior is occurring, does the student seem unaware of anything else going on around him/her?

Never	Almost Never	Seldom	Half the Time	Usually	Almost Always	Always
0	1	2	3	4	5	6

14. Does this behavior stop occurring shortly after (one to five minutes) you stop working or making demands on him/her?

Never	Almost Never	Seldom	Half the Time	Usually	Almost Always	Always
0	1	2	3	4	5	6

15. Does he/she seem to do this behavior to get you to spend some time with him/her?

Never	Almost Never	Seldom	Half the Time	Usually	Almost Always	Always
0	1	2	3	4	5	6

16. Does this behavior seem to occur when the student's been told that he/she can't do something he/she had wanted to do?

Never	Almost Never	Seldom	Half the Time	Usually	Almost Always	Always
0	1	2	3	4	5	6

Place score for each item in corresponding space:

Sensory	Escape	Attention	Tangibles
1.	2.	3.	4.
5.	6.	7.	8.
9.	10.	11.	12.
13.	14.	15.	16.
T=	T=	T=	T=

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ABC Data Sheet

Name: _____

An ABC Chart is a direct observation tool that can be used to collect information about the events that are occurring within a student's environment. "A" refers to the antecedent, or the event or activity that immediately precedes a target behavior. The "B" refers to observed behavior, and "C" refers to the consequence, or the event that immediately follows a response. It is used to organize information over several observation sessions by recording the types of behaviors observed, the events that precede and follow the behavior, and allows an observer to record descriptive information in a systematic and organized way. However, it can be more difficult to see patterns quickly, and the data may need to be summarized to look for patterns related to antecedents and consequences.

Target Behavior:

	Date:	Date:	Date:	Date:
Antecedent What happened before/during behavior?				
Operationalize the Behavior				
Consequence What happened After the behavior?				

Patterns Identified:

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Scatter Plot

Name: _____

The scatter plot is a direct observation interval recording tool used in the functional assessment process to identify when problem behaviors occur and can help you discover patterns related to a target behavior and specific time periods. The scatter plot is a grid with time plotted on the vertical line divided into periods of time. For example, the time listed on the grid might be divided into 15-minute periods, or in another situation it may be more useful to use 30 minute or 1-hour periods depending upon the type of behavior and the length of time you are observing. The horizontal line on the scatter plot designates the date the observation occurs.

Scatter Plot Assessment Tool

Date ____/____/____

Behavior:

Directions: At the end of each time interval, fill in the square indicating the appropriate time and date on the chart using the code given below:

Time:

0800									
0815									
0830									
0845									
0900									
0915									
0930									
0945									
1000									
1015									
1030									
1045									
1100									
1115									
1130									
1145									

Date:

This page intentionally left blank

Name: _____

Behavioral Map Assessment Tool

Directions: Place an "X" in the space that corresponds to the time and date of each observed target behavior. Look for clusters of behavioral incidents suggesting meaningful patterns. Attempt to match behaviors to possible influences related to settings, academic tasks, level of adult supervision, and other instructional or environmental variables.

Behavior: _____

Dates: _____
 Monday Tuesday Wednesday Thursday Friday

Bedroom					

Patterns Identified:

This page intentionally left blank

Name: _____

Date: _____

INTELLECTUAL AND ADAPTIVE SKILLS*

List observed strengths/weaknesses in each of the following areas

AREA	STRENGTHS	WEAKNESSES
Communications		
Self-care		
Home living		
Social skills		
Community use		
Self-direction		
Health & safety		
Academics		
Leisure		
Work		
Psychological		
Health		

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Name: _____

Task Analysis:

Task: _____

Steps: (some tasks will need more or less steps)

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.
- 7.
- 8.
- 9.
- 10.

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Name: _____

Pharmacology math Practice

Complete the following problems. Do not use a calculator. Please show your work in the area provided.

Problem:	Show your work:	Answer:
1. Order: 1000 mg Stock: 500 mg per tab		
2. Order: 150 mg Stock: 300 mg per tab		
3. Order: 1 ½ grains Stock: ½ grain per tab		
4. Order: 0.3 mg Stock: 0.6 mg per tab		
5. Order: 1 mg Stock: 0.5 mg per 1ml		
6. Order: 250 mg Stock: 500 mg per tab		
7. Order: 900 mg Stock: 300 mg per tab		

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The following pages are to be completed at:
OPARC - Diversified Industries (DI)
or
Pomona Valley Workshop (PVW)

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MENT 72L

Submit upon completion

Name:

Date:

Documentation

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Date	Time	All entries are to be signed with name and title

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Faculty comments:

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Name: _____

Training Plan

A – Baseline (current production, time frame to produce...):

P – (operationalized goal):

Milestone 1:

Milestone 2:

Milestone 3:

I –

Reinforcers

- 1.
- 2.
- 3.

Prompts (must match level of restrictiveness given in operationalized goal)

- 1.
- 2.
- 3.

E -

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Tally Sheet

Name: _____

Directions: Use the chart below to tally the individuals' productivity during the given time frame.

Time:

0800									
0815									
0830									
0845									
0900									
0915									
0930									
0945									
1000									
1015									
1030									
1045									
1100									
1115									
1130									
1145									

Date:

This page intentionally left blank

Name: _____

Date: _____

INTELLECTUAL AND ADAPTIVE SKILLS*

List observed strengths/weaknesses in each of the following areas

AREA	STRENGTHS	WEAKNESSES
Communications		
Self-care		
Home living		
Social skills		
Community use		
Self-direction		
Health & safety		
Academics		
Leisure		
Work		
Psychological		
Health		

This page intentionally left blank

Name: _____

Task Analysis:

Task: _____

Steps: (some tasks will need more or less steps)

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.
- 7.
- 8.
- 9.
- 10.

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Name: _____

MAKING MEASURABLE OBJECTIVES

Make the following objectives measurable: **FORMULA** - Client will (desired action) (when) (for how long) (how often) (under what circumstance) (duration of time being measured) with (level of independence) by (date).

1. Client will crush aluminum cans.
2. Client will sit in chair.
3. Client will feed himself by himself.
4. Client will stop walking when he comes to an intersection.
5. Client will choose his own clothes to wear.
6. Client will decrease the number of cigarettes smoked.
7. Client will respond to a stimulus.
8. Client will sign the word "break."
9. Client will write "thank you" cards when he receives a gift.
10. Client will learn to self-administer medications.

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NAME: _____

SELF ASSESSMENT FOR PVW

*******Please provide situational examples when answering questions*******

1. Explain how you maintain a friendly, positive, supportive attitude with the consumers served at PVW.
2. Explain how you maintain a friendly attitude with the PVW staff.
3. When you are working with the PVW consumers, how do you keep them actively involved?
4. Explain some of the ways and situations in which you have praised a PVW consumer.
5. How do you observe to help determine a consumer's strengths, weaknesses, likes and dislikes?
6. When working with the PVW consumers how do you actively listen to what the consumer has to say?
7. What opportunities have you found for giving the PVW consumers choices?
8. Explain how you refrain from providing too much help to the PVW consumer, allowing them the opportunity to work through a barrier on his/her own.

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9. Explain how you reinforce appropriate behavior for consumers at PVW.
10. Explain your communication skills for the PVW consumers. .
11. Explain how you make yourself useful/offer your services when you see a need.
12. Why is it important to avoid gossip and negative commentary about the PVW consumers and staff?
13. Explain how you maintain high expectations for the PVW consumers
14. Explain how you feel that you are making a contribution to PVW.

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The following pages are to be completed at:

Casa Colina

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Name: _____

Training Plan

A – Baseline:

P – (operationalized goal):

Milestone 1:

Milestone 2:

Milestone 3:

I –

Reinforcers

- 1.
- 2.
- 3.

Prompts (must match level of restrictiveness given in operationalized goal)

- 1.
- 2.
- 3.

E –

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Weekly Assessment of Client Progress
Week of _____ to _____

Physical Assessment					
Client Initials		Respirations			
Pain scale	0 1 2 3 4 5 6 7 8 9 10	Skin Integrity	Intact Not Intact		
LOC / Orientation	Person Place Time Circumstance	Ambulatory	Y N		
G-Tube	Y N	Hearing Impairment	Y N		
Vision Impairment	Y N	Proper Body Alignment	Y N		
Communicates	Verbal Non-Verbal	Contractures	Y N		
Range of motion	Full Limited	Affected Limbs	R L R L Arms Legs		
List all adaptive equipment:					

Training Assessment					
I – Independent: Able to perform for self with or without device. S – Supervision: No physical help required; needs cueing or to be monitored, even with device. A – Assistance: Physical help required, even with device. D – Dependent: Unable to do for self, even with physical help, cueing or device.					
Feeding	I S A D	Dressing	I S A D	Toileting	I S A D
Transfers	I S A D	Ambulation	I S A D	Sensory Stimulation	I S A D
Standing balance	I S A D	Injury prevention skills	I S A D	Motor Coordination	I S A D
Sitting Balance	I S A D	Wears Adaptive Equipment	I S A D	Participates in activity	I S A D

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Social Assessment					
I – Independent: Able to perform for self with or without device. S – Supervision: No physical help required; needs cueing or to be monitored, even with device. A – Assistance: Physical help required, even with device. D – Dependent: Unable to do for self, even with physical help, cueing or device.					
Conflict resolution (peer)	I	S	A	D	
Conflict resolution (staff)	I	S	A	D	
Initiates interactions	I	S	A	D	
Asks for help	I	S	A	D	
Interacts w/ peers	I	S	A	D	
Participates in social activity	I	S	A	D	
Manages feelings	I	S	A	D	
Displays sense of humor	Yes	No			
Appropriate eye contact	Yes	No			
Isolative	Yes	No			
Disruptive	Yes	No			
Appropriate physical contact	Yes	No			

Leisure Skills					
Participates in:					
Sports	Indoor	Outdoor	Art – Painting / chalk / water color	Yes	No
Table Games	Yes	No	Arts & Crafts	Yes	No
Puzzles	Yes	No	Music	Yes	No
Exercise / Fitness / Dance	Yes	No	Conversations with friends	Yes	No
Card Games	Yes	No	Gardening	Yes	No
Watches T.V. / Movies	Yes	No	Karaoke	Yes	No
Suggests Outings	Yes	No	Picks leisure activity	Yes	No

Coping Skills					
Attitude / Affect	Bright	Flat	Blunted	Cooperative	Impulsive
	Withdrawn	Depressed	Angry	Sad	Fearful
					Euphoric
Distractibility	High	Medium	Low	Approx. x _____	per 5 min session
Communicates Likes / Dislikes	Yes	No	How:		
Comprehension / Processing Time	0-5 Seconds	6-10 Seconds	11-15 Seconds	16-20 Seconds	Other _____
Seeks Validation	Yes	No	How:		
Communication Skills	Verbal	1-3 words sentences	Full sentences	Nonverbal	
	Gestures	Picture Exchange	Augmented	ASL	
Attention Span	Approx. _____ min.	Maintains Eye Contact	Yes	No	
Appropriate social responses	Yes	No	Asks for clarification appropriately	Yes	No

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Weekly Assessment of Client Progress
Week of _____ to _____

Physical Assessment					
Client Initials		Respirations			
Pain scale	0 1 2 3 4 5 6 7 8 9 10	Skin Integrity	Intact Not Intact		
LOC / Orientation	Person Place Time Circumstance	Ambulatory	Y N		
G-Tube	Y N	Hearing Impairment	Y N		
Vision Impairment	Y N	Proper Body Alignment	Y N		
Communicates	Verbal Non-Verbal	Contractures	Y N		
Range of motion	Full Limited	Affected Limbs	R L R L Arms Legs		
List all adaptive equipment:					

Training Assessment					
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Feeding	I S A D	Dressing	I S A D	Toileting	I S A D
Transfers	I S A D	Ambulation	I S A D	Sensory Stimulation	I S A D
Standing balance	I S A D	Injury prevention skills	I S A D	Motor Coordination	I S A D
Sitting Balance	I S A D	Wears Adaptive Equipment	I S A D	Participates in activity	I S A D

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Social Assessment					
I – Independent: Able to perform for self with or without device. S – Supervision: No physical help required; needs cueing or to be monitored, even with device. A – Assistance: Physical help required, even with device. D – Dependent: Unable to do for self, even with physical help, cueing or device.					
Conflict resolution (peer)	I	S	A	D	
Conflict resolution (staff)	I	S	A	D	
Initiates interactions	I	S	A	D	
Asks for help	I	S	A	D	
Interacts w/ peers	I	S	A	D	
Participates in social activity	I	S	A	D	
Manages feelings	I	S	A	D	
Displays sense of humor	Yes	No			
Appropriate eye contact	Yes	No			
Isolative	Yes	No			
Disruptive	Yes	No			
Appropriate physical contact	Yes	No			

Leisure Skills					
Participates in:					
Sports	Indoor	Outdoor	Art – Painting / chalk / water color	Yes	No
Table Games	Yes	No	Arts & Crafts	Yes	No
Puzzles	Yes	No	Music	Yes	No
Exercise / Fitness / Dance	Yes	No	Conversations with friends	Yes	No
Card Games	Yes	No	Gardening	Yes	No
Watches T.V. / Movies	Yes	No	Karaoke	Yes	No
Suggests Outings	Yes	No	Picks leisure activity	Yes	No

Coping Skills					
Attitude / Affect	Bright	Flat	Blunted	Cooperative	Impulsive
	Withdrawn	Depressed	Angry	Sad	Fearful
					Euphoric
Distractibility	High	Medium	Low	Approx. x _____	per 5 min session
Communicates Likes / Dislikes	Yes	No	How:		
Comprehension / Processing Time	0-5 Seconds	6-10 Seconds	11-15 Seconds	16-20 Seconds	Other _____
Seeks Validation	Yes	No	How:		
Communication Skills	Verbal	1-3 words sentences	Full sentences	Nonverbal	
	Gestures	Picture Exchange	Augmented	ASL	
Attention Span	Approx. _____ min.	Maintains Eye Contact	Yes	No	
Appropriate social responses	Yes	No	Asks for clarification appropriately	Yes	No

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Weekly Assessment of Client Progress
Week of _____ to _____

Physical Assessment					
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Pain scale	0 1 2 3 4 5 6 7 8 9 10	Skin Integrity	Intact Not Intact		
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Vision Impairment	Y N	Proper Body Alignment	Y N		
Communicates	Verbal Non-Verbal	Contractures	Y N		
Range of motion	Full Limited	Affected Limbs	R L R L Arms Legs		
List all adaptive equipment:					

Training Assessment					
I – Independent: Able to perform for self with or without device. S – Supervision: No physical help required; needs cueing or to be monitored, even with device. A – Assistance: Physical help required, even with device. D – Dependent: Unable to do for self, even with physical help, cueing or device.					
Feeding	I S A D	Dressing	I S A D	Toileting	I S A D
Transfers	I S A D	Ambulation	I S A D	Sensory Stimulation	I S A D
Standing balance	I S A D	Injury prevention skills	I S A D	Motor Coordination	I S A D
Sitting Balance	I S A D	Wears Adaptive Equipment	I S A D	Participates in activity	I S A D

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Social Assessment					
I – Independent: Able to perform for self with or without device. S – Supervision: No physical help required; needs cueing or to be monitored, even with device. A – Assistance: Physical help required, even with device. D – Dependent: Unable to do for self, even with physical help, cueing or device.					
Conflict resolution (peer)	I	S	A	D	
Conflict resolution (staff)	I	S	A	D	
Initiates interactions	I	S	A	D	
Asks for help	I	S	A	D	
Interacts w/ peers	I	S	A	D	
Participates in social activity	I	S	A	D	
Manages feelings	I	S	A	D	
Displays sense of humor	Yes	No			
Appropriate eye contact	Yes	No			
Isolative	Yes	No			
Disruptive	Yes	No			
Appropriate physical contact	Yes	No			

Leisure Skills					
Participates in:					
Sports	Indoor	Outdoor	Art – Painting / chalk / water color	Yes	No
Table Games	Yes	No	Arts & Crafts	Yes	No
Puzzles	Yes	No	Music	Yes	No
Exercise / Fitness / Dance	Yes	No	Conversations with friends	Yes	No
Card Games	Yes	No	Gardening	Yes	No
Watches T.V. / Movies	Yes	No	Karaoke	Yes	No
Suggests Outings	Yes	No	Picks leisure activity	Yes	No

Coping Skills					
Attitude / Affect	Bright	Flat	Blunted	Cooperative	Impulsive
	Withdrawn	Depressed	Angry	Sad	Fearful
					Euphoric
Distractibility	High	Medium	Low	Approx. x _____	per 5 min session
Communicates Likes / Dislikes	Yes	No	How:		
Comprehension / Processing Time	0-5 Seconds	6-10 Seconds	11-15 Seconds	16-20 Seconds	Other _____
Seeks Validation	Yes	No	How:		
Communication Skills	Verbal	1-3 words sentences	Full sentences	Nonverbal	
	Gestures	Picture Exchange	Augmented	ASL	
Attention Span	Approx. _____ min.	Maintains Eye Contact	Yes	No	
Appropriate social responses	Yes	No	Asks for clarification appropriately	Yes	No

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Weekly Assessment of Client Progress
Week of _____ to _____

Physical Assessment					
Client Initials		Respirations			
Pain scale	0 1 2 3 4 5 6 7 8 9 10	Skin Integrity	Intact Not Intact		
LOC / Orientation	Person Place Time Circumstance	Ambulatory	Y N		
G-Tube	Y N	Hearing Impairment	Y N		
Vision Impairment	Y N	Proper Body Alignment	Y N		
Communicates	Verbal Non-Verbal	Contractures	Y N		
Range of motion	Full Limited	Affected Limbs	R L R L Arms Legs		
List all adaptive equipment:					

Training Assessment					
I – Independent: Able to perform for self with or without device. S – Supervision: No physical help required; needs cueing or to be monitored, even with device. A – Assistance: Physical help required, even with device. D – Dependent: Unable to do for self, even with physical help, cueing or device.					
Feeding	I S A D	Dressing	I S A D	Toileting	I S A D
Transfers	I S A D	Ambulation	I S A D	Sensory Stimulation	I S A D
Standing balance	I S A D	Injury prevention skills	I S A D	Motor Coordination	I S A D
Sitting Balance	I S A D	Wears Adaptive Equipment	I S A D	Participates in activity	I S A D

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Social Assessment					
I – Independent: Able to perform for self with or without device. S – Supervision: No physical help required; needs cueing or to be monitored, even with device. A – Assistance: Physical help required, even with device. D – Dependent: Unable to do for self, even with physical help, cueing or device.					
Conflict resolution (peer)	I	S	A	D	
Conflict resolution (staff)	I	S	A	D	
Initiates interactions	I	S	A	D	
Asks for help	I	S	A	D	
Interacts w/ peers	I	S	A	D	
Participates in social activity	I	S	A	D	
Manages feelings	I	S	A	D	
Displays sense of humor	I	S	A	D	
Appropriate eye contact	Yes	No			
Isolative	Yes	No			
Disruptive	Yes	No			
Appropriate physical contact	Yes	No			

Leisure Skills					
Participates in:					
Sports	Indoor	Outdoor	Art – Painting / chalk / water color	Yes	No
Table Games	Yes	No	Arts & Crafts	Yes	No
Puzzles	Yes	No	Music	Yes	No
Exercise / Fitness / Dance	Yes	No	Conversations with friends	Yes	No
Card Games	Yes	No	Gardening	Yes	No
Watches T.V. / Movies	Yes	No	Karaoke	Yes	No
Suggests Outings	Yes	No	Picks leisure activity	Yes	No

Coping Skills					
Attitude / Affect	Bright	Flat	Blunted	Cooperative	Impulsive
	Withdrawn	Depressed	Angry	Sad	Fearful
					Euphoric
Distractibility	High	Medium	Low	Approx. x _____	per 5 min session
Communicates Likes / Dislikes	Yes	No	How:		
Comprehension / Processing Time	0-5 Seconds	6-10 Seconds	11-15 Seconds	16-20 Seconds	Other _____
Seeks Validation	Yes	No	How:		
Communication Skills	Verbal	1-3 words sentences	Full sentences	Nonverbal	
	Gestures	Picture Exchange	Augmented	ASL	
Attention Span	Approx. _____ min.	Maintains Eye Contact	Yes	No	
Appropriate social responses	Yes	No	Asks for clarification appropriately	Yes	No

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Name: _____

Date: _____

INTELLECTUAL AND ADAPTIVE SKILLS*

List observed strengths/weaknesses in each of the following areas

AREA	STRENGTHS	WEAKNESSES
Communications		
Self-care		
Home living		
Social skills		
Community use		
Self-direction		
Health & safety		
Academics		
Leisure		
Work		
Psychological		
Health		

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Name _____

During your time in the med room at Casa Colina's Adult Day Health Center (ADH) or in the gymnasium at the Transitional Living Center (TLC), create a task analysis.

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.
- 7.
- 8.
- 9.
- 10.
- 11.
- 12.
- 13.
- 14.
- 15.

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Name _____

Review the objectives listed in the Ment 72L syllabus. Maintain an ongoing weekly journal listing all of the clinical objectives you have addressed during the Casa Colina rotation with your supporting evidence of how you have met the objectives. **Multiple objectives should be met each day.** If more space is needed, please use the back of this form.

Example:

Day & Date	Objectives from Syllabus	Evidence of meeting objectives
Tuesday (Date)	Create opportunities for choice	I offered clients a variety of activity options and let them choose the one (s)he wanted.

Casa Colina Location Assigned: _____

Day & Date	Objectives from Syllabus	Evidence of meeting objectives
Tuesday		
Wednesday		
Thursday		
Friday		

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Name _____

Review the objectives listed in the Ment 72L syllabus. Maintain an ongoing weekly journal listing all of the clinical objectives you have addressed during the Casa Colina rotation with your supporting evidence of how you have met the objectives. **Multiple objectives should be met each day.** If more space is needed, please use the back of this form.

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Day & Date	Objectives from Syllabus	Evidence of meeting objectives
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Casa Colina Location Assigned: _____

Day & Date	Objectives from Syllabus	Evidence of meeting objectives
Tuesday		
Wednesday		
Thursday		
Friday		

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Name _____

Review the objectives listed in the Ment 72L syllabus. Maintain an ongoing weekly journal listing all of the clinical objectives you have addressed during the Casa Colina rotation with your supporting evidence of how you have met the objectives. **Multiple objectives should be met each day.** If more space is needed, please use the back of this form.

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Casa Colina Location Assigned: _____

Day & Date	Objectives from Syllabus	Evidence of meeting objectives
Tuesday		
Wednesday		
Thursday		
Friday		

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Name _____

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Casa Colina Location Assigned: _____

Day & Date	Objectives from Syllabus	Evidence of meeting objectives
Tuesday		
Wednesday		
Thursday		
Friday		

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Name: _____

Chart Assignment

List the following information for your assigned client:

1. Allergies:
2. Diet Texture:
3. Liquid Texture:
4. Level of Supervision:
5. Adaptive Equipment: (all)
6. Treatments:
7. Summarize All Training/Behavior Objectives (AM shift):

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Name: _____

Investigate the available resources at Casa Colina's Adult Day Health Center (ADH) and create and lead an age appropriate activity focusing on **leisure, fine motor skills, or gross motor skills**.

Name of activity:

Supplies needed:

Set up of activity:

Skills necessary for participation in activity:

Sensory motor systems being utilized:

Task analysis of the activity:

Outcome:

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The following pages are to be completed at:

OPARC – Adult Day Center (ADC)

Or

Summit Services (SS)

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MENT 72L

Submit upon completion

Name:

Date:

Documentation

Document an interaction you have had with a consumer. Use a narrative format to identify consumer's physical status, participation in treatment or work, and methods of communication. Remember to document the consumer's appearance, behaviors, and communication skills.

Date	Time	All entries are to be signed with name and title

Faculty comments:

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MENT 72L

Submit upon completion

Name:

Date:

Documentation

Document an interaction you have had with a consumer. Use a narrative format to identify consumer's physical status, participation in treatment or work, and methods of communication. Remember to document the consumer's appearance, behaviors, and communication skills.

Date	Time	All entries are to be signed with name and title

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MENT 72L

Submit upon completion

Name:

Date:

Documentation

Document an interaction you have had with a consumer. Use a narrative format to identify consumer's physical status, participation in treatment or work, and methods of communication. Remember to document the consumer's appearance, behaviors, and communication skills.

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MENT 72L

Submit upon completion

Name:

Date:

Documentation

Document an interaction you have had with a consumer. Use a narrative format to identify consumer's physical status, participation in treatment or work, and methods of communication. Remember to document the consumer's appearance, behaviors, and communication skills.

Date	Time	All entries are to be signed with name and title

Faculty comments:

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Name: _____

Functional Communication Plan

A –

1st level assessment –

2nd level assessment – list the results from the following assessments

R+ Inventory -

Commun. Assessment Tool -

Communication Questionnaire -

+Environ. Checklist -

Baseline (what, where, when, with whom):

P – (operationalized goal):

Milestone 1:

Milestone 2:

Milestone 3:

I –

Reinforcers

1.

2.

3.

Reinforcement schedule -

Prompts (must match level of restrictiveness given in operationalized goal)

1.

2.

3.

E -

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Communication Questionnaire

Cue Questions:		Crying	Aggression: tantrum/SIB	Shakes 'No/' nods 'Yes'	Facial expression	Passive gaze	Gaze shift	Proximity	gestures/pointing	Gives object	Pulling other's hand	Touching/moving others	Face/body	Grabs/reaches	Motor agitation	Removes self/ walks away	Vocalization/noise	Tone of voice	Self stimulation	Echolalia	One-word speech	One-word signs	Complex speech	Combined signs	Comments:
Requests for affection/interaction																									
What if the Client wants:																									
Adult to sit near																									
Peer to sit near																									
Adult to look at him/her																									
To cuddle/embrace																									
Other																									
Requests for adult action																									
What if the Client wants:																									
Help with dressing																									
To read a book																									
To play ball/a game																									
To go outside/to a store																									
Other																									
Request for object, food...																									
What if the Client wants:																									
An object out of reach																									
A door/container opened																									
A favorite food																									
Music/radio/ T.V.																									
Toy/book																									
Other																									
Protest																									
What if:																									
Common routine is dropped																									
Favorite toy not available																									
Favorite food not available																									
Adult terminates interaction																									
Dr. / Dentist appl.																									
Doesn't want to do a task																									
Taken out w/out desire																									
Other																									
Declaration/comment																									
What if the Client wants:																									
To show you something																									
You to look at something																									
Other																									

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Positive Environment Checklist

The Positive Environment Checklist (PEC) is designed for use in evaluating whether the settings in which persons with severe disabilities live, work and go to school are structured in a manner that promotes and maintains positive, adaptive behaviors. It also addresses concerns related to the ways in which staff support and interact with the people with disabilities in the setting. Positive environments will help to minimize the occurrence of maladaptive behaviors. The Positive Environment checklist focuses on the physical, social, and practical structure of the environment.

Client's Name _____ Date _____

Section 1: Physical Setting

- | | | | | |
|----|--|-----|----|---------|
| 1. | Is the physical setting clean, well lighted and odor free? | YES | NO | UNCLEAR |
| 2. | Is temperature regulation in the setting adequate? | YES | NO | UNCLEAR |
| 3. | Is the physical setting visually pleasant and appealing? | YES | NO | UNCLEAR |
| 4. | Does the arrangement of the setting promote easy access for all individuals within the setting? | YES | NO | UNCLEAR |
| 5. | Is the setting arranged in a manner that facilitates needed staff support and supervision? | YES | NO | UNCLEAR |
| 6. | Does the setting contain or provide interesting, age-appropriate items and materials for people to use? | YES | NO | UNCLEAR |
| 7. | Is the setting located and structured in a manner that promotes and facilitates physical integration into the "regular" community? | YES | NO | UNCLEAR |

Section 2: Social setting

- | | | | | |
|----|--|-----|----|---------|
| 1. | Is the number of people in this setting appropriate for its physical size and purpose? | YES | NO | UNCLEAR |
| 2. | Are the people who share this setting compatible in terms of age, gender, and support needs? | YES | NO | UNCLEAR |
| 3. | Do the people who share this setting get along with each other? | YES | NO | UNCLEAR |
| 4. | Is the staff ratio in this setting adequate to meet the support needs of all the people here at all times? | YES | NO | UNCLEAR |

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5.	Does staff actively work to develop and maintain a positive rapport and relationship with the people here?	YES	NO	UNCLEAR
6.	Does staff promote and facilitate opportunities for social integration with people who are not paid to provide service?	YES	NO	UNCLEAR

Section 3: Activities and Instruction

1.	Do people in this setting regularly participate (whether with support, partial participation or independently) in activities and tasks that are useful and meaningful to their daily lives?	YES	NO	UNCLEAR
2.	Do people participate in a variety of different activities?	YES	NO	UNCLEAR
3.	Do people participate in activities that occur in “regular” community settings outside of the home, school, or work place?	YES	NO	UNCLEAR
4.	Do people in this setting receive instruction on activities or skills that are useful and meaningful to their daily lives?	YES	NO	UNCLEAR
5.	Is the instruction that people receive individualized to meet specific learner needs?	YES	NO	UNCLEAR
6.	Are peoples’ personal preferences taken into account when determining the activities and tasks in which they participate and receive training?	YES	NO	UNCLEAR

Section 4: Scheduling and Predictability

1.	Is there a system or strategy used to identify what people in this setting should be doing and when?	YES	NO	UNCLEAR
2.	Are there means to determine whether the things that should be occurring actually do occur?	YES	NO	UNCLEAR
3.	Do people in this setting have a way of knowing or predicting what they will be doing and when?	YES	NO	UNCLEAR
4.	Does staff prepare people in this setting in advance for changes in typical schedules or routines?	YES	NO	UNCLEAR
5.	Do people in this setting have opportunities to exercise choice in terms of what they will do, when, with whom, and what rewards they will receive?	YES	NO	UNCLEAR

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Section 5: Communication

1.	Do people in this setting have “acceptable” means to communicate basic messages (wants, comments, rejections) to staff or others in this setting?	YES	NO	UNCLEAR
2.	Does staff promote and reward communication?	YES	NO	UNCLEAR
3.	Are effective, efficient communication strategies being used by or taught to the people in this setting?	YES	NO	UNCLEAR
4.	Is staff familiar with the receptive language levels and skills of the people in this setting?	YES	NO	UNCLEAR
5.	Does staff have “acceptable” means to communicate basic messages to the people in this setting?	YES	NO	UNCLEAR

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REINFORCEMENT INVENTORY

Client's Name: _____ Date: _____

Completed by: _____

DESCRIPTION OF POTENTIALLY REINFORCING EVENTS	NOT AT ALL	A LITTLE	A FAIR AMOUNT	MUCH	VERY MUCH
A. FOOD ITEMS					
1. Candy					
What kind?					
a.					
b.					
c.					
2. Ice Cream					
What kind?					
a.					
b.					
c.					
3. Nuts					
4. Chips					
5. Cake					
6. Cookies					
7. Beverages					
What kind?					
a.					
b.					
8. Other Foods					
a.					
b.					
B. TOYS AND PLAY THINGS					
1. Racing Cars					
2. Electric Trains					
3. Bicycle					
4. Skate Board					
5. Playing with Dolls					
a.					
b.					
C. ENTERTAINMENT					
1. Watching T.V.					
Favorite Programs?					
a.					
b.					
2. Movies					
3. Dancing					
4. Drawing					
5. Building Models					
6. Working with Tools					
7. Working with Clay					
8. Musical Group					
9. Other:					
D. EXCURSIONS / COMMUNITY					
1. Riding in Car					
2. Going to work with Mother/Father					
3. Visiting grandparents or relatives					
4. To the beach					
5. Picnic					

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DESCRIPTION OF POTENTIALLY REINFORCING EVENTS	NOT AT ALL	A LITTLE	A FAIR AMOUNT	MUCH	VERY MUCH
6. Vacation (Where?)					
7. Airplane ride					
8. Going out to eat (which meals? Where?)					
9. Visit a friend (Who?)					
10. Visit a city (Where?)					
11. To a museum					
12. To a store (Name?)					
13. Going for a walk					
14. To the library					
15. To the amusement park					
16. Other:					
E. SOCIAL INTERACTION, AFFILIATION					
1. Playing with others (Whom?)					
2. Being praised by...					
a. Parent					
b. Teacher					
c. Friends					
d. Other					
Being praised in what way...					
a. Out loud					
b. With an award					
c. Other					
3. Being hugged					
4. Pat on the back					
5. High 5					
6. Handshake					
7. Talking with others (Who?)					
10. Kidding and joking					
11. Parties					
12. Dances					
13. Taking a friend out (Who?)					
14. Happy faces, Smiles					
15. Other					
F. ACADEMIC / CLASSROOM					
1. Learning a new language					
2. Taking a music lesson					
3. Reading					
4. Being read to					
5. Looking at books					
6. Going to school					
7. Helping teacher					
8. Helping others					
9. Listen to music					
10. Get a drink					
11. Other:					
G. DOMESTIC ACTIVITIES					
1. Baking					
2. Repairing / building					
3. Gardening					
4. Cooking					
5. Washing the car					
6. Sewing					
7. Shopping					

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DESCRIPTION OF POTENTIALLY REINFORCING EVENTS	NOT AT ALL	A LITTLE	A FAIR AMOUNT	MUCH	VERY MUCH
H. PERSONAL APPEARANCE					
1. Getting new clothes					
2. Putting on make-up					
3. Purchasing make-up					
4. Wearing special clothes					
5. Dressing in a costume					
6. Going to a salon					
7. Manicure					
8. Pedicure					
9. Massage					
10. Wearing jewelry					
11. Having picture taken					
12. Other					
a.					
b.					
I. OTHER EVENTS AND ACTIVITIES					
1. Staying up late					
2. Having a pet					
3. Listening to stories					
4. Decorating room					
5. Sleeping in					
6. Subscription to a magazine					
7. Attention given in group					
8. Alone time					
9. Work in special setting					
10. Other					
J. TOKEN REINFORCERS					
1. Stars on a chart					
2. Happy / smiley faces					
3. Special badges					
4. Certificates					
5. Signatures					
6. Points					
7. Money					
8. Movie tickets					
9. Other:					
K. OTHER					

List below those events or activities the person does more than:

5 times a day?	10 times a day?
15 times a day?	20 times a day?

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How much time does the person spend in the following activities (e.g., hours, minutes)?

Watching T.V.?	Sleeping?
Listening to music?	Alone?
Playing with others?	Reading?
Playing with toys?	Playing alone?
Talking on the telephone?	Organized sports?
Sitting around	Eating?

What is the person's favorite thing to do?

What is the person's least favorite thing to do?

What does the person ask for most?

What does the person complain about most?

What does the person try to avoid most?

This page intentionally left blank

Name: _____

Communication Assessment Tool

Directions: Make a list of the different places in your environment, and then closely observe the client. Place an "X" in the space that corresponds to the place of each observed communication. Look for clusters of behavioral incidents suggesting meaningful patterns. Attempt to match communication to possible influences related to settings, academic tasks, level of adult supervision, and other instructional or environmental variables.

Types of communication observed:

Dates:

Monday

Tuesday

Wednesday

Thursday

Friday

P
L
A
C
E
S

Bedroom					

Patterns Identified:

This page intentionally left blank

Name: _____

Date: _____

INTELLECTUAL AND ADAPTIVE SKILLS*

List observed strengths/weaknesses in each of the following areas

AREA	STRENGTHS	WEAKNESSES
Communications		
Self-care		
Home living		
Social skills		
Community use		
Self-direction		
Health & safety		
Academics		
Leisure		
Work		
Psychological		
Health		

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Name: _____

Pharmacology math Practice

Complete the following problems. Do not use a calculator. Please show your work in the area provided.

Problem:	Show your work:	Answer:
1. Order: Keflex 500mg cap QID x10 days. Stock: Keflex 250mg cap x 12 How many Keflex need to be ordered from the pharmacy?		
2. An order for Tylenol 500mg TID x 3 days was given on Monday at 1700 and it is now Wednesday at 0800, how many doses does the client have left?		
3. Order: 60 mg of amoxicillin QID x 10 days Stock: 150mg per 10ml How many milliliters of solution will be administered?		
4. An order for Vistaril 25mg QID x 5 days was received on Monday at 1200. When will the last dose be administered to the client?		
5. A solution contains penicillin 250mg/5ml. The doctor has ordered 15ml of the solution to be administered BID. How much penicillin did the doctor order?		

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The following assignment is to be done
During WEEK #3

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Name: _____

Below is a list of maladaptive behaviors and their function as assessed by the Motivation Assessment Scale. For each, create an operationalized functionally equivalent adaptive replacement behavior that uses the same amount or less energy and is incompatible (if possible). Each operationalized statement should be written as a goal on a positive behavioral support plan - **FORMULA** - Client will (desired action) (when) (for how long) (how often) (under what circumstance) (duration of time being measured) with (level of independence) by (date).

1. Screams "NO" for Escape
2. Hits peers for Attention
3. Vomits for Escape
4. Ingests cigarette butts for Sensory (addiction)
5. Hits self on the head for Sensory (pain)
6. Takes magazine away from peer for Tangible
7. Tugs constantly on staff's shirt for Attention
8. Cries for Tangible
9. Takes food from peers for Sensory (hunger)
10. Hugs staff for Attention
11. Throws self on floor for Escape
12. Biting self for sensory (frustration)

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The following assignment is to be done
During WEEK #7

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Self Administration of Medication (SAM)

Client's initials _____ Assessed by _____ Date _____

	YES	NO	N/A	TRNG OPP	COMMENTS
SELF IDENTIFICATION					
Says own name?					
Points to picture of self?					
Comes forward when his/her name is called?					
Can identify self by other method?					
Does not respond?					
PHYSICAL ABILITIES					
Can take medication without spilling?					
Can grasp a spoon?					
Can swallow medication with fluid or food?					
Can open medication package?					
After opening medication, can empty it into med cup?					
MEDICATION INFORMATION					
Does this person know medication by color?					
Does this person know medication by name?					
Does this person know what each medication is treating (symptoms)?					
Does this person know what each medication is treating (diagnosis)?					
If applicable, has this client identified that new medication was administered?					
Does this person have a history of refusing medications?					
Does this person know how to read?					
TIMING					
Does this person know how to tell time?					
Does this person need a watch?					
Does this person know, in general, when his/her medications are administered?					
Does this person know exactly what time medications are administered?					
Does this person know exactly what medications are taken at what time?					
If applicable, has this person recognized that a medication was given at an unusual time?					
DOSAGE					
Does this person know how many pills are taken at what time?					
Does this person know how to read the pharmacy label?					
Is the pharmacy label clear for a person to read (no medical symbols)?					
ADMINISTRATION					
Does this person wash his/her hands prior to administration of medications?					
Can this person pour water/fluids into a cup?					
With what agent does this person swallow medications?					
Does this person have a history of cheeking medications?					
Are there special precautions to assure medications are swallowed?					
Does the client have any behavioral barriers that may interfere with SAM?					

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Name: _____

Based on the SAM, write a training plan related to choice making and self administration of medication.

Operationalized Goal (TOM) -

Reinforcers

1.

2.

3.

Prompts

1.

2.

3.

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The following assignment is to be done
During WEEK #8

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Seizure Assignment

Name: _____

Look up the following medications and fill in the missing information:

Generic Name	Trade Name	Side Effects (bold or underlined)	Drug/Drug Interactions	Patient Education
carbamazepine				
	Luminal			
gabapentin				
lamotrigine				
	Dilantin			
diazepam				
	Ativan			
clorazepate				
Valproic acid				
levetiracetam				

List interventions for the following seizure types during each phase:

Seizure Type	Pre-Ictal	Ictal	Post-Ictal
Simple Partial			
Complex Partial			
Absence			
Myoclonic			
Tonic/Clonic			
Atonic			

Status Epilepticus			
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*Note – some types of seizures are so brief, there may not be interventions for every stage.

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The following assignment is to be done
During WEEK #9

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Name: _____

Sensory Motor Assignment

Ment 72L

Identify a deficit in three (3) sensory motor areas, describe how the client compensates for the deficit, how the staff compensates for the deficit, and an intervention to help stimulate / calm the corresponding sensory motor system.

Sensory Motor System: _____

Deficit observed: _____

Client compensated by _____

Staff compensates by _____

Create an intervention to address the observed deficit. (State whether you need to calm or stimulate the corresponding sensory motor system) _____

Sensory Motor System: _____

Deficit observed: _____

Client compensated by _____

Staff compensates by _____

Create an intervention to address the observed deficit. (State whether you need to calm or stimulate the corresponding sensory motor system) _____

Sensory Motor System: _____

Deficit observed: _____

Client compensated by _____

Staff compensates by _____

Create an intervention to address the observed deficit. (State whether you need to calm or stimulate the corresponding sensory motor system) _____

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The following assignment is to be done
During WEEK #12

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Name: _____

Due: _____

Etiology: _____

Lifespan Planning - Write an operationalized goal for each aspect of the life stages listed below.

CHILDHOOD

Nutrition –

Socialization –

Accompanying Condition (r/t etiology) –

ADOLESCENCE

Education –

Socialization –

Accompanying Condition (r/t etiology) –

ADULT

Home –

Employment –

Transportation –

Socialization –

Financial –

Older Adulthood

Home –

Leisure –

Transportation –

Socialization –

Financial –

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The following assignment is to be done
During WEEK #14

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Human Sexuality Assessment:

Does this person...

1	Respond to his/her name?	Yes	No	N/A
2	Tolerate, at a passive level, contact from others (e.g. eye contact/physical contact)?	Yes	No	N/A
3	Recognize that others can help meet his/her own wants or needs?	Yes	No	N/A
4	Respond, at an active level, to the presence of others?	Yes	No	N/A
5	Recognize the difference between familiar and unfamiliar careproviders (e.g. staff/family members)?	Yes	No	N/A
6	Engage in interactions with familiar care providers?	Yes	No	N/A
7	Maintain contact with familiar care providers?	Yes	No	N/A
8	Seek out familiar care providers?	Yes	No	N/A
9	Exhibit specific peer preferences?	Yes	No	N/A
10	Engage in interactions with familiar peers?	Yes	No	N/A
11	Maintain contact with familiar peers?	Yes	No	N/A
12	Seek out familiar peers?	Yes	No	N/A
13	Identify him/herself as male/female, boy/girl, or man/woman?	Yes	No	N/A
14	Identify others as male/female, boy/girl, man/woman?	Yes	No	N/A
15	Name/identify basic body parts (e.g. head, feet, hands, legs, arms) on self?	Yes	No	N/A
16	Name/identify basic body parts (e.g. head, feet, hands, legs, arms) on others?	Yes	No	N/A
17	Name/identify basic body parts (e.g. genitals, buttocks, breasts) on self?	Yes	No	N/A
18	Name/identify basic body parts (e.g. genitals, buttocks, breasts) on others?	Yes	No	N/A
19	Masturbate?	Yes	No	N/A
20	Masturbate in private and appropriate places (e.g. bathroom, bedroom)?	Yes	No	N/A
21	Masturbate at appropriate times (e.g. not during activities or programming)?	Yes	No	N/A
22	Masturbate to climax/ejaculation?	Yes	No	N/A
23	Masturbate without causing injury to him/herself?	Yes	No	N/A
24	Make decisions, with a yes or no when given a choice?	Yes	No	N/A
25	Decline (say "no") to engage in sexual activity with others?	Yes	No	N/A
26	Understand the basic functions/concepts of sexual intercourse?	Yes	No	N/A
27	Talk/ask questions appropriately concerning sexual matters?	Yes	No	N/A
28	Speak appropriately when discussing the desire to have sex with others or a desired partner?	Yes	No	N/A
29	Understand that it is inappropriate to touch another person's sexual body parts without their consent?	Yes	No	N/A
30	Demonstrate affection to others in an appropriate manner?	Yes	No	N/A
31	Indicate knowledge that others have a right to privacy (e.g. does not climb in bed with others)?	Yes	No	N/A
32	Refrain from attempting to engage "passive" clients in sexual activity?	Yes	No	N/A
33	Have knowledge that sexual intercourse is only appropriate with mutually agreeing others and in private?	Yes	No	N/A
34	Date/show interest in a member of the opposite sex?	Yes	No	N/A
35	Date/show interest in a member of the same sex?	Yes	No	N/A
36	Understand the staff-client relationship?	Yes	No	N/A
37	Understand the client-client relationship?	Yes	No	N/A
38	Know that every act of heterosexuality intercourse can result in pregnancy?	Yes	No	N/A
39	Understand the responsibility of being a sexually active adult?	Yes	No	N/A
40	Know that specific diseases can only be transmitted through sexual activity?	Yes	No	N/A

Recommendations

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Date: _____

Signature: _____

Title:

Human sexuality assessment form. (Reproduced with permission of The Matheny School and Hospital, Peapack, New Jersey)

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Name: _____

Sexuality Plan

Based on the Human Sexuality Assessment, create a sexuality plan:

Operationalized Goal (TOM) -

Reinforcers –

1.

2.

3.

Prompts –

1.

2.

3.

