

ICF/ID RECORD REVIEW FORM
(Focused-fundamental survey items are indicated in blue.)

Name: _____ Facility: _____ DOA: _____ DOB: _____

Guardian: _____ Phone: _____

Diagnosis: _____

Allergies: _____

Date of IPP: _____

Dental: _____

Quarterly Pharmacy Reviews: _____

Assistive/Mechanical Supports: Are the items below included in the IPP? Yes No

Dentures: _____ Walker: _____ Orthotics: _____

Glasses: _____ Wheelchair: _____ Communication Device: _____ Bedrails: _____

Hearing Aids: _____ Cane/Gait Belt: _____ Adaptive Eating Equipment: _____ Other: _____

IPP Objectives: Assessments and IPP must address the following:

Task	✓	Task	✓	Task	✓	Task	✓
Toileting		Hygiene		Oral Care		Eating	
Bathing		Dressing		Grooming		Communication	
SAM		Money Management		Community Integration		Maladaptive behaviors	
Other:		Other:		Other:		Other:	

All objectives and training programs must address: frequency (the program is run at 100% as defined in the program), technical adequacy (single behavior, measurable), assigned a priority level, assigned a target date, assigned a responsible party, data reflects the objective, progress or regress is monitored, and revisions are made to the IPP as needed.

QIDP Monitoring & other concerns based on observation:

Psychotropic medication or other restrictive interventions employed with sufficient safeguards	Start Date	HRC Consent Date	Guardian Consent Date	Informed Consent	Less Restrictives	Behavior Plan	Replacement Behavior	Plan to Reduce Use (W295 & W312) & Tied to Behavior	TD Date	Blood Level Date

END FOCUSED FUNDAMENTAL SURVEY HERE

COMPLETE FOR EXTENDED OR FULL SURVEY

Childhood Immunizations meet recommendations: ____ yes ____ no. If no, documentation from Physician: ____yes ____no ____n/a

- Tetanus and Diphtheria (at least 1x every 10 years) Date: _____
- Tb Screening (upon admission) Date: _____
- Cholesterol Level (every 3-5 years if WNL) Date: _____
- Occult Blood Test (start @ age 50, annual if no other colorectal testing) Date: _____
- Colonoscopy every 10 years (may substitute for occult blood testing) Date: _____
- Flu Vaccine (yearly if high risk) Date: _____
- Pneumococcal Vaccine: (1 time after age 65, or risk factors exist) Date: _____
- DEXA Scan (every 3 years if risk factors exist) Date: _____
- Zoster (1 time after age 50 2 doses 2nd 2 – 6 mos after first unless contraindicated) Date: _____
- HPV vaccine (age = ♀ 9-26, ♂ 9-21, 2 shots, 3 if started over the age of 15) Date: _____
- [Female] Mammography (baseline 40-49, every 2 years @ age 50 - 74) Date: _____
- [Female] Pap with Pelvic (every 5 years for women over 30) Date: _____

Medical & Nursing:

History/Physical: _____ Vision: _____ Hearing: _____
 Quarterly Nursing Reviews: _____

IPP Review: In Attendance:

- _____ Client
- _____ Parent
- _____ Guardian
- _____ Family Members
- _____ QIDP
- _____ Home Manager
- _____ Direct Care Staff
- _____ Nurse
- _____ Administrator
- _____ Dietician
- _____ OT/PT/SLP
- _____ Social Worker
- _____ Day Site Staff
- _____ Professionals
- _____ Teacher

Comprehensive Functional Assessment:

Evaluation	Date	Recommendations
Dietary		
OT		
PT		
Speech		
Social		
Psychological		
Behavioral		
Psychiatric		
Vocational		
IEP (from school)		
Neurological		
Labs		
Other		
Other		