Residential Services Provider (RSP) Review of Client Progress on IPP Objectives

Please complete and submit this form to ACRC to meet the Quarterly, Semi-Annual and Annual IPP review requirement

Client Name:	**Meeting Date:**
Facility Name:	**Telephone:**
Height: **Weight:**	**Conservator Name:**
Payee Name:	**P&I Balance:**
Health Care Plan Required: Yes ☐ No ☐ For what condition(s):	
Medical Coverage: ☐ **Medi-Cal** ☐ **Managed Care Plan name:** ☐ **Private Insurance name:** ☐ **Medicare** ☐ **Other**	
Allergies, i.e., medication, food, environment:	

Physician Name	Address	Telephone #	Type of Exam	Date of Last Exam
			Annual Physical	
			Dental yearly	
			Optometrist (2 years)	
			Psychiatrist	
			Podiatrist	
			Hearing (2-3 years)	
			Neurologist	

Other Medical appointments:

Name of Medical Professional	Address	Telephone #	Reason for Appointment/Outcome	Date of Appointment
Last seizure type and date (If applicable):				

Medications:**

(List the name of the medication, what the dosage is, the route (meaning by mouth, inhaled, topically, per rectum, etc.) and how frequently it's administered, the reason for prescribing it, and the name of the prescribing physician. Example: Depakote, 100 mgs, by mouth, one pill-two times daily for the treatment of seizures, Dr. Foot).

Medication	Dosage	Route	Frequency	Reason Prescribed	Physician

** ACRC expects Facility Administrator to discuss with the client's physician the reasons why each medication is being prescribed. The Facility Administrator should provide medical data (e.g., seizure activity, behavioral patterns and mental health status) necessary for the physician to ensure the appropriate dosage of medication is prescribed.

Medications taken can result in a variety of possible side effects. The Facility Administrator must document any <u>observed or reported</u> side effects experienced by the client while taking any of the medications listed above.

Medication:	Side Effect(s):

If the client has been hospitalized since the last reporting period, Facility Administrator must document the name of the hospital, the reason for and date(s) of the stay. Reminder, each hospitalization will result in the need for a Special Incident Report (SIR) being submitted.

Hospital Name	Reason	Date(s) of stay

Some medication require periodic blood level monitoring. The Facility Administrator should request that the physician indicate if this is necessary and document this information in the client's file; it should also be provided to the ACRC Service Coordinator.
The Facility Administrator must ensure that blood work is completed per the recommended frequency of the prescribing physician.

Examples of medications that require periodic blood level monitoring: Amitriptyline (Elavil), Carbamazepine (Tegretol), Cyclosporine (Neoral, Gengraf), Desipramine (Norpramin), Digoxin (Lanoxin), Imipramine (Tofranil), Lithium (Lithobid, Eskalith), Nortriptyline (Pamelor), Phenobarbital (Luminal), Phenytoin (Dilantin), Primidone (Mysoline), Theophylline (Theo-Dur), Valproic Acid (Depakote, Depakene), Coumadin.

Name of Medication	Frequency of Blood Level Monitoring	Date of Blood Test	Blood Test Results

TEST RESULTS

Reason for blood test:	
Last Blood test date:	**Medication:**
Last Blood test results: ☐ **Low** ☐ **Normal** ☐ **High**	
☐ **C.B.C.** ☐ **Homoglobin AIC** ☐ **RPR** ☐ **P.S.A.** ☐ **TH/TSH** ☐ **Lipid Panel** ☐ **Glucose**	
☐ **Electrolytes** ☐ **LFT** ☐ **Cholesterol:_____** ☐ **HDL** ☐ **LDL** ☐ **Triglyceride**	
☐ **FBS** ☐ **Chem Panel 6** ☐ **Chem Panel 20**	

Date of Blood Test	Blood Test Results

HEALTH SCREENINGS

Blood Pressure	**Date:**	**Results:**
Cholesterol Check	**Date:**	**Results:**
Colon Screening (5 years after 50)	**Date:**	**Results:**
Prostate Screen for Men (5 years after 50)	**Date:**	**Results:**
Osteoporosis (first at 50 and 2 years after 60)	**Date:**	**Results:**
Mammogram 1-2 yrs., yearly from age 40-65	**Date:**	**Results:**
Pap Smear: (yearly, if sexually active)	**Date:**	**Results:**

SHOTS

Flu Shot (Yearly) Date:	**Tetanus Booster (every 10 years) Date:**	**PPD/TB Skin Test Date:**
Pneumococcal (5 yrs. after 50) Date:	**Hepatitis B Series Dates:**	**Hepatitis A (1 time) Date:**
Whooping Cough Booster Date:		

IN THIS REPORTING PERIOD

Special Incident Reports:		
Date	**Reason**	**Follow-up and preventative measures**

Recreational Activities and Family Visits:	
Date	**Activity**

Consultant(s) (for Level 4 Facilities Only)			
Name	**Hours**	**Type**	**Reason for Use**

Provide a summary of the current levels of performance for each IPP objective. When completing an objective for behaviors or hygiene (A.D.L. skill level), please include the frequency, prompt used and the outcome.

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Facility Administrator Signature:	**Date:**