State of Illinois
Division of Developmental Disabilities
State Operated Developmental Centers

INDIVIDUAL PROFILE

I am interested in living in the community. If you would like to meet me, please contact _____ ,

_____ at Choate Developmental Center
(phone number)

General Demographic Information

1. Full Name: _____ Date of Birth: _____ Gender: _____ Race: _____
(Month/Day/Year)

2. Legally responsible person: Self If Guardian: Not Applicable

3. Interests/Preferences: (As described by the individual, legal guardian, and/or staff who know the individual best)

   a. Food likes/dislikes: _____

   b. Work/School interests: _____

   c. Fun and relaxation interests: _____

   d. Social Interests: _____

   e. What I don't like: _____

   f. Geographic Preferences: _____

   g. Spiritual wants/interests: _____

   h. Other significant interests/preferences: _____

   i. The important people in my life are: _____

   j. My dreams for the future are: _____

   k. What most people like about me best: _____

   l. What I like best about others: _____

   m. My gifts and talents are: _____

General Physical Status:

a. Mobility:

Walks: Independent Stairs: Independent Help Needed with Mobility: None

Bed: None of the day Wheelchair: Not applicable Transfers: Independent

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b. Fall Risk: None Identified

e. Vision: See Well (May Wear Glasses)

c. Fracture Risk: None Identified

f. Hearing: Hears Normal Voices (May use Hearing Aid)

d. Primary Language Understood: English
(If Other) _____

g. Primary Means of Expression: Speaks

Self Help Skills Status:

a. Eating: Independent

d.Dressing: Independent

b. Bathing: Independent

e.Toothbrushing: Independent

c. Toileting: Independent

f. Medication Administration: Independent

Current Day Program Type: _____

Diagnosis

Axis I - _____

Axis II - _____

Axis III - _____

_____

Axis IV - _____

Axis V - GAF = _____ **ICAP or SIB-R Score:** _____

Health Status:

a. Health Issues (Describe limitations in daily activity, minimum required care by nurse or physician, frequency of seizures, etc):

b. Current diet/dietary restrictions: _____ Height: _____ Weight: _____ BP: _____

c. Allergies--Food: _____ Environmental: _____

Medications: _____ Reactions to medications: _____

d. Current Medications schedule: _____

e. Current treatments: _____

_____

f. Protective devices/medical equipment: _____

_____

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Services and Supports Needed:

Physical Therapy	None	Neurological	None
Occupational Therapy	None	Behavioral Health	None
Speech Therapy	None	Psychological	None
Nutrition/Dietary	None	Psychiatric	None
Dental	None	Other:	

Identify Current Behavioral Supports in the Home and Day Program:

Brief Outline of Behavior Plan:

Behavior Frequency of Occurrences (List behavior and the average number of occurrences per behavior):

	daily		daily
	daily		daily
	daily		daily

Court Involvement (if applicable)

Additional Information: (Elaborate on any section of this Individual's Profile)

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Community Agency Response

Are you interested in pursuing the transition process for this individual? Yes

If you are answering No at this time, what services are needed for this individual that your agency is not able to provide? Please be as specific as possible. This information will be most helpful in developing and providing community services for this individual. Your input will assist in building the community service delivery system in Illinois.

Community Agency Information

Completed By: _____ Title: _____ Date Completed: _____

Contact Person: _____ Title: _____ Phone: _____

Please fax this completed page to: _____ at _____ .