ARION CARE SOLUTIONS, LLC
Preservice/Member Orientation

Personal/Confidential Information

Is Provider a Family Member: Yes ☐ No ☐
Relationship to member: _____

Last Name:	**First Name:**	**Middle Initial:**

Phone Number:	**Address**	**City**	**State**	**Zipcode**

Sex: Female: ☐ Male: ☐	**Date of Birth:**	**Diagnosis:**

Responsible Party/Guardian Name/Relationship:	**Phone#**	**Email Address:**

Funding Source Contact DDD: ☐ **ASSIST ID** DDD:_____	UHC: ☐ Banner: ☐ **AHCCCS ID** EPD:_____	Private Pay: ☐ **PRIVATE PAY ID** Private:_____

Funding Source phone # and Email address: _____

Days: **Sun ☐ M ☐ T ☐ W ☐ TH ☐ F ☐ Sat☐**	**Services & Number of Hours** **RSP**_____**ATC**_____**HAH**_____**Private:** _____

Schedule: _____

Emergency Contact Information

Primary Care Physician:	**Physician's Phone #:**
Urgent Care Facility/Hospice/Hospital:	**Address:**
Secondary Contact's Name & Relationship:	**Secondary Contact's phone # & Email address**

Medical Information (See Medication List on page 4)

Allergies To: N/A ☐
Food ☐ Bee/Insects ☐ Medications ☐ Other _____
Description of allergic reaction and recommended response
_____
_____

Diabetic: Yes ☐ No ☐
Pills ☐ Injections ☐ Reminders ☐ N/A ☐
General Special Instructions:
_____
_____

Protective Devices Yes ☐ No ☐
Purposes:_____
Instructions for use: _____
_____

Skin integrity: N/A ☐
Are there any skin integrity issues Yes ☐ No ☐
If yes, what part of the body is it?_____
If yes, is there a treatment plan in place and what is it?
_____
Prescriber of Treatment

Seizures: Yes ☐ No ☐
Description: _____
Frequency: _____
Approx. Duration: _____

Catheter: Yes ☐ No ☐ **Ostomy:** Yes ☐ No ☐
Special Instructions: _____
_____
_____

Mobility: (Balance while standing)
Excellent ☐ (not an issue)
Moderate ☐ (stumbles, etc)
Poor ☐ (very unsteady, falls)
No Mobility ☐ (full assistance req)

Fall Risk:
No Risk ☐
Moderate ☐ (fall precaution)
Poor ☐ (fall risk)
No Mobility ☐ (high fall risk)

Mobility Aids: ☐ N/A ☐ AFO's ☐ Wheelchair ☐ Walker
☐ Leg Braces ☐ Gait belt ☐ Crutches ☐ 2 person lift
☐ Cane Mechanical Lift Brand/Model (ie Hoyer) :
_____

Is there a valid DNR in place? Yes ☐ No ☐
If yes where is it located? _____

Member Name	**Provider Name**

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Assistive Devices For:
Vision: Glasses ☐ Contacts ☐ N/A ☐
Hearing: Hearing Aid ☐ N/A ☐
Other Device: _____

Dental Appliances:
Dentures ☐ Partials ☐ Full ☐ N/A ☐

Required Consistency of Food:
Normal ☐ Chopped ☐ Pureed ☐

Drinking:
Independent in obtaining beverages:
Yes ☐ No ☐
Independent in requesting beverages:
Yes ☐ No ☐
Any thickening Agents required: Yes ☐ No ☐

Eating: Does food present a choking hazard? Yes ☐ No ☐ Tube Feeding: Yes ☐ No ☐
Special Diet: _____
Special Instructions: _____
Eating Disorder: Yes ☐ No ☐ _____
Explain: _____

Communication Skills:
Uses complex sentences: ☐ Uses simple sentences: ☐ Signs: ☐ Nods yes/no: ☐ Gestures: ☐
Describe Augmentative Communication Devices (if applicable) _____

Other Pertinent Information:
List who lives in the home and their relationship: _____
List any animals in the home: _____
Electronic Monitoring System : Yes ☐ No ☐ Devices used (camera in residence, medical alert, etc.):

BEHAVIORAL CONCERNS *(If applicable)*

Brief Description	Frequency	Topography	Intensity		
		(what does the behavior look like)	Severe	Moderate	Mild
Aggression N/A ☐			☐	☐	☐
Self-Injurious Behavior N/A ☐			☐	☐	☐
Property Destruction N/A ☐			☐	☐	☐
Flight Risk N/A ☐			☐	☐	☐
Self - Stimulation N/A ☐			☐	☐	☐
Sexual Acting Out N/A ☐			☐	☐	☐

Unsupervised Time Alone: Yes ☐ No ☐ If yes, duration of unsupervised time (hours)_____
Days of week: Sun ☐ M ☐ T ☐ W ☐ TH ☐ F ☐ Sat ☐ Location:(bedroom (door locked), anywhere in home, community) in home

The supervision of this member is based on the assessed needs as defined on the Risk Assessment of the Planning Document : Constant supersivion is required : Yes ☐ No ☐

Are there any Specialized Training classes required: Yes ☐ No ☐
Specialized Training: _____

Is a Behavioral Support Plan Available for Additional Information: Yes ☐ No ☐
Reason for BSP: _____

Member Name	Provider Name

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ADL's	Description	Level of assistance Needed		
		Total	Partial	Indep.
Bathing	tub ☐ shower ☐ bed bath ☐ bath seat ☐ sponge bath ☐	☐	☐	☐
Hair Care	shampoo ☐ brush/comb ☐ dry hair ☐	☐	☐	☐
Oral Care	brush teeth ☐ dentures ☐ full/partial ☐	☐	☐	☐
Shave	Yes ☐ No ☐ N/A ☐ Describe Method:_____	☐	☐	☐
Nail Care	clean & file: Yes ☐ No ☐ **(do not cut toe nails if Diabetic)**	☐	☐	☐
Skin Care	Lotion to dry skin - Frequency: _____	☐	☐	☐
Dressing	elastic ☐ buttons ☐ snaps ☐ zippers ☐ tying ☐	☐	☐	☐
Undressing	elastic ☐ buttons ☐ snaps ☐ zippers ☐ tying ☐	☐	☐	☐
Toileting	bedside commode ☐ bedpan/urinal ☐ chux ☐ menses ☐ depends ☐ diapers ☐	☐	☐	☐
Transfers	sitting/standing ☐ in/out of bed ☐ in/out of vehicle ☐ Hoyer Lift: ☐ Gait Belt ☐ 50+lbs (2person lift) ☐ N/A ☐	☐	☐	☐
Ambulation	walking ☐ stairs ☐ wheelchair ☐ walker ☐ cane ☐	☐	☐	☐
ADL's: Instrumental	**Description**	**Level of Assistance Needed**		
		Total	**Partial**	**Indep.**
Home	Using the telephone	☐	☐	☐
Community	Getting in/out of vehicle or public transport	☐	☐	☐
Community	Grocery shopping, Dr. appointments, activities	☐	☐	☐
Meal	Meal prep, reminders: yes ☐ no ☐ Assist with: feeding ☐ cutting/set up ☐	☐	☐	☐
Home	Housework or Enviromental Safety Support	☐	☐	☐
Home	Doing laundry, light housekeeping	☐	☐	☐
Medication	Administered by: Self ☐ Family ☐ Other: _____	☐	☐	☐
Financial	Manages own Finances: Yes ☐ No ☐ Responsible party: _____	☐	☐	☐
	Power of Attorney or P.O.A (If applicable) List Name, Contact #, Email P.O.A. Attached: Yes ☐ No ☐ _____ ***Guardianship(court ordered): Yes ☐ No ☐*** ***List Name, Contact #, Email*** _____			
Staff Will	1. Observe universal precautions 2. Provide general safety supervision.			

By signing this document, each party acknowledges that the information contained herein is true and correct. All parties have been provided the opportunity to ask any questions and understand all answers and all parties agree to comply with this agreement. It is also acknowledged that a digital (electronic) signature is intended to authenticate this writing and to have the same force and effect as a manual signature. This document will act as a mutual agreement between parties for provision of services.

Name of Person Completing Form: _____	**Relationship:** _____	**Date:** _____
Member/Responsible Person (Print)	**Member/Responsible Person (Sign)**	**Date:**
Provider's Name (Print)	**Provider's Name (Sign)**	**Date:**
Member Name: _____		**Date:** _____

No Medication to Report Yes☐ No ☐

Medication List

Member Name: _____

Provider Name: _____ **Date:** _____

Medication	Dosage	Route	Frequency	Purpose	Notes

Any other notes/comments:

Member/Responsible Party (Print) _____ **Date:** _____

Member/Responsible Party(Signature) _____

Revised 8/23/19; 12/15/19; 2/5/20; 2/15/20; 8/25/20; 9/24/20