The Strong Center for Developmental Disabilities

in the Division of Developmental & Behavioral Pediatrics

Short Term Care Guide

Fillable Guide to Prepare for an Unexpected Change in Care

NAME: **DATE:**

PERSONAL INFORMATION

Address

Phone Number

EMERGENCY CONTACT(S)

Name:

Phone Number

Relationship to Individual

*Identify a non-local family member or other care member to act as the second emergency contact.

Contact 2:

Phone Number

Relationship to Individual

CARE MANAGER/COORDINATOR

Name:

Phone Number

Agency

HOUSEHOLD INFORMATION

Primary Caregiver 1 :

Address

Phone Number

Legal Guardian?

Yes

Primary Caregiver 2:

Address

Phone Number

Legal Guardian?

Yes

OTHERS WHO PROVIDE CARE

Name:

Address

Phone Number

Legal Guardian?

Yes

Notes

Name:

Address

Phone Number

Legal Guardian?

Yes

Notes

DAILY ROUTINE

SLEEP SCHEDULE

General Bedtime

General Waking

Sleep Concerns

Tips/tricks for supporting good sleep

Special routines, objects, or activities

Other notes:

OTHER INFORMATION

Preferred activities

Sensory aversions

Behavioral triggers

Communication style

Use of a communication device?

Yes **No** **Type:**

PERSONAL HYGIENE

Are the following completed independently?

	Yes	No	Sometimes
Bathing			

Support needed

	Yes	No	Sometimes
Brushing teeth			

Support needed

	Yes	No	Sometimes
Using Restroom			

Support needed

	Yes	No	NA
During menstrual cycle			

Support needed

Products/strategies to manage cycle

SCREENTIME ROUTINE

Preferred screen activities

Limits

Other guidelines

ALLERGIES & DIET

ALLERGY INFORMATION

Allergy #1

Allergy

Reaction

Treatment

Allergy #2

Allergy

Reaction

Treatment

Allergy #3

Allergy

Reaction

Treatment

DIET INFORMATION

Favorite foods

Special dietary instructions

Behavioral or other strategies for meals

Food intolerances/reactions

Other information

CARE PROVIDERS & SAFETY

SCHOOL/ CHILDCARE/ WORKPLACE INFORMATION

Name of Organization | Phone Number

Address

Notes

Type: School | Daycare | Workplace | Residential Facility

Preferred contact #1 | Phone Number

Preferred contact #2 | Phone Number

SCHOOL/ CHILDCARE/ WORKPLACE INFORMATION

Name of Organization | Phone Number

Address

Notes

Type: School | Daycare | Workplace | Residential Facility

Preferred contact #1 | Phone Number

Preferred contact #2 | Phone Number

SAFETY INFORMATION

(e.g., wandering or running away, eating things that are not food)

Risk factors:

Successful or preferred safety supports:

OTHER INFORMATION

Location of relevant documents (e.g., school records, IEP/504, job coaching plan):

Location of communication devices/ sensory objects/ other supports:

What services provided are provided at school or in the workplace?

HEALTH INFORMATION

IMPORTANT MEDICAL/BEHAVIORAL HEALTH INFORMATION

Name of Pharmacy

Phone Number

Address

Primary Care Provider

Phone Number

Address

Insurance Policy Plan

Insurance Policy #

Medical Notes

DENTIST

Name

Address

Phone Number

Insurance Policy Plan

Insurance Policy #

Notes

MEDICATIONS

Medication #1

Name

Dose

Instructions

Notes (refills, etc.)

Medication #2

Name

Dose

Instructions

Notes (refills, etc.)

Medication #3

Name

Dose

Instructions

Notes (refills, etc.)

HEALTH PROVIDERS

SPECIALTY PROVIDERS

Specialty Provider #1

Provider Name | Phone Number

Address

Provider specialty | Insurance Policy Plan

Medical Notes | Insurance Policy # | Frequency of visits

Specialty Provider #2

Provider Name | Phone Number

Address

Provider specialty | Insurance Policy Plan

Medical Notes | Insurance Policy # | Frequency of visits

Specialty Provider #3

Provider Name | Phone Number

Address

Provider specialty | Insurance Policy Plan

Medical Notes | Insurance Policy # | Frequency of visits

OTHER MEDICAL INFORMATION

Describe how the individual gets to medical appointments and any special instructions

Location of health records:

MEDICAL INFORMATION

MEDICAL EQUIPMENT INFORMATION

Equipment #1

Name of Equipment		*Location*	
Purpose			
Serial Number		*Expiration Date*	
Supplier Name		*Supplier Phone #*	
Notes on using equipment			

Equipment #2

Name of Equipment		*Location*	
Purpose			
Serial Number		*Expiration Date*	
Supplier Name		*Supplier Phone #*	
Notes on using equipment			

Equipment #3

Name of Equipment		*Location*	
Purpose			
Serial Number		*Expiration Date*	
Supplier Name		*Supplier Phone #*	
Notes on using equipment			

This fillable guide was developed by the Strong Center for Developmental Disabilities in the Division of Developmental and Behavioral Pediatrics at the University of Rochester Medical Center.

The Strong Center for Developmental Disabilities (SCDD) is one of 67 University Centers for Excellence in Developmental Disabilities and is a member of the Association of University Centers on Disabilities (AUCD), a network of interdisciplinary centers advancing policy and practice for individuals with developmental and other disabilities, their families, and communities through research, education, and service.

UNIVERSITY of ROCHESTER MEDICAL CENTER

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