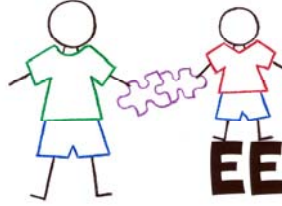


Exceptional Expectations, L.L.C.



Helping families put together the pieces.

P.O. Box 1723 Apache Junction, AZ 85217 p. 480-209-4357 f. 480-636-7597
www.exceptionalexpectations.com
exceptionalexpectations@yahoo.com

Pre-Service Provider Orientation

Instructions: This form is to be completed by the Provider and individual and/or responsible party receiving services prior to the initiation of services. A copy MUST be retained by the provider and a copy sent to the District Office. The provider must also ensure that a General Consent and Authorization form is completed and retained by the provider.

PROVIDER INFORMATION

Agency/Provider Name Exceptional Expectations, L.L.C.

Special Training The following special training is necessary to work with this child:

Medical Training No Yes

Seizure Management Training No Yes

Other special training (Please describe) _____

CRITICAL INFORMATION

Client Name: _____ Date of Birth: _____
Last, First Middle MM/DD/YYYY

SSN: _____-_____-_____

Address: _____
Street No./P.O. Box Apt./Ste./Bldg City State Zip-code

Parent/Responsible Party: _____ Relationship: _____

Address: same as above _____
Street No./P.O. Box Apt./Ste./Bldg City State Zip-code

Phone: h _____ W _____ C _____

Emergency Contact: _____
Name Relationship Phone

Emergency Contact: _____
Name Relationship Phone

Support Coordinator _____
Name Office Phone

Primary Care Physician _____
Name Phone

Client Name: _____ Date of Birth: _____

HEALTH – MEDICAL

Current medications and significant historical medication issues:

Medical log required? No Yes Special medication instructions? No Yes

Medications taken regularly: _____

Pertinent medical conditions: No Yes _____

ALLERGIES TO:

Food: No Yes _____

Medication: No Yes _____

Environmental: No Yes _____

Other: No Yes _____

Recommended response to allergic reaction: _____

SEIZURES: No Yes Describe: _____

Frequency (# per hour/day/week): _____ Approximate duration: _____

Recommended response to seizure activity: _____

ASSISTIVE DEVICES:

Vision: _____ Hearing: _____ Dental appliances: _____

Communication: Type: _____ Do you own? No Yes

PROTECTIVE DEVICES:

Instructions for use: _____

Purpose: _____

FOOD:

Does food present a choking hazard? No Yes Describe: _____

Special Diet No Yes _____

Tube feeding No Yes _____

Eating Disorder No Yes _____

COMMUNICATION:

Describe communication abilities _____

BEHAVIORAL CONCERNS:

CIT Training Needed: No Yes Behavior Treatment Plan: No Yes

Brief description of behavior _____ Frequency _____

Recommended Intervention _____

SIGNATURES

Signature of person who completed form Relationship to child Date

Print Providers Name Provider's Signature Date

Print Parent/Responsible Party's Name Parent/Responsible Party's Signature Date