DEVELOPMENTAL CENTER
Essential Healthy Life Style Plan (EHLSP)

Ohio | Department of Developmental Disabilities

Date of Admission: _____ Date of Annual from _____ to _____ Date of Discharge: _____

GENERAL				
Name of Individual:	DOB:	Sex:	Height:	Weight:
Name of DC:	Name of PCP:	Name of Nurse Completing Form:		

MEDICAL

Check here ONLY IF Ohio **DNR-CC or DNR-CCA** is attached_____ (a properly authorized DNR-DNR-CC must be attached to be valid)

IMMUNIZATIONS:	DATE LAST GIVEN:	DATE NEXT DUE:	IMMUNIZATIONS:	DATE LAST GIVEN:	DATE NEXT DUE:	IMMUNIZATIONS:	DATE LAST GIVEN:	DATE NEXT DUE:
D.P.T			Hep. B			P.P.D.		
Shingles			Flu			Pneumonia		
D.T./T.T.								

MEDICAL OVERVIEW

ALLERGIES:

DIAGNOSIS CURRENT:

DIAGNOSIS HISTORY:

MY MEDICAL AND HEALTH INFORMATION

*(Include any known **dates** of **original diagnosis**; most **recent evaluations** and **outcome**s, lab tests, screenings; current treatments and appliances/adaptive devices; list names of **specialists** and **other** related **providers**)*

Additional prompts are in RED italics- prompts are clarifications/reminders; to include but not limited to

DELETE PROMPTS as you complete each section-

DETAILS AND EXPLANATIONS OF MY HEALTH INFORMATION

(Include explanations of diagnosis and conditions; important considerations for monitoring, treatment and support; include what is important TO the individual including supports and preferences that may be contraindicated;

describe the functional presentation of the diagnosis/condition and implications of condition and responses to condition/treatments; Personal adaptive behavior, device usage indications; safety concerns;

PERSON-CENTERED ACTIONS MY TEAM AND I WANT OR NEED TO TAKE

(bullet point action steps)

- Include date of appointments that are scheduled
- or date next due
- action steps for accommodating what is important TO the person
- steps FOR health and safety
- address accommodations of TO vs FOR
- include functional coping and support strategies and steps

ALLERGIES: *current and past medication and environmental allergies; date of last reaction*	*How allergies present; treatments; avoidance and interventions; individual's awareness and self-protection; last known reaction*	*Urgent/emergent actions, prescriptions and avoidance*
VISION: *includes diagnoses and corrections*		
DENTAL: *conditions, devices, and presentations including special hygiene if applicable, chewing swallowing and other oropharyngeal issues*		
EAR (HEARING)/NOSE/THROAT: *current functions including hearing; swallowing and other oropharyngeal issues (if not applicable to or listed in to dental); ENT related appliances*		
NEUROLOGY: *seizures, strokes, neuro related sleep disturbances, hyper/hypo sensitivities*		
PSYCHIATRY: *include psych related sleep issues*		
CARDIOLOGY:		
RESPIRATORY: *include sleep apneas;*		
SKIN: *include podiatry if applicable*		
GI / DIETARY: *appliances*		
MUSCULAR/SKELELTAL: *orthotics, mobility, orthopedics, podiatry*		
REPRODUCTIVE/URINARY: *includes toileting*		
ENDOCRINE / HORMONAL / METABOLISM: *includes lymphatic*		
MEDICATIONS:		
TREATMENTS:		

RESOURCES (*DC nursing, specialists, clinics etc.***):**	**RESOURCE CONTACT INFORMATION:**

_____

RN/LPN Signature / Date

_____

DON Review and Approval Signature / Date