HOUSE OF POSSIBLITIES, INC.

350 Washington Street, North Easton, MA 02356
Tel: 508-205-0555 Fax: 508-205-0557

2017 Face Sheet
(year)

Name				Date of Admission/First Service			
Current Address						Home Number	
Former Address						Citizenship	
Sex	Date of Birth	Place of Birth	Height	Weight	Hair	Eyes	Identifying Marks
Race		School Status (i.e. HS graduate, GED, College, HS certificate, no schooling, current student)					
Primary Diagnosis				Secondary Diagnosis			
Known Allergies				Reaction/Allergy Treatments			
Social Security Number				Medicare/ Mass Health Number			
Medical Insurance				Policy Number			
Custody, Guardianship and/or Commitment Status and/or Legal Competency Status							
If not competent, Legal Guardian Name				Home Phone		Work Phone	Cell Phone
Address							
If applicable, Co-Guardian Name				Home Phone		Work Phone	Cell Phone
Co- Guardian Address							
Mother's Name				Marital Status		Home Phone	Cell Phone
Mother's Address							
Father's Name				Marital Status		Home Phone	Cell Phone
Father's Address							
Do you Receive Outside Funding? ◯YES/◯NO If YES, Name of Funding Agency:				Agency Contact Name			Phone

AFFIX CURRENT, CLEAR PHOTOGRAPH

To affix, open this PDF in Acrobat Reader and click on the section above. Select "Browse". If on a mac, select "Options" in the bottom left. Select the file type you would like to upload from the dropdown.

Otherwise, attach a photograph to the document when you return the form.

Primary Language		Ability for Self-Preservation
Significant Behavior Characteristics (i.e. SIB &/or Aggression)	History of wandering/ separating from group? (please circle) ◯Yes /◯No If yes, please explain:	Likely Response to Search (i.e. hide, respond, ask for help)
Pattern of Movement if Lost Previously		Places Frequented
Relevant Capabilities/Limitations/Preferences		Probable Dress

IN CASE OF EMERGENCY, PLEASE LIST CLOSEST RELATIVE OR CONTACT PERSON(S) IF PARENT(S) AND/OR GUARDIAN(S) CANNOT BE REACHED

Name	**Home Phone**	**Work Phone**	**Cell Phone**	**Relationship**
Address				
Name	Home Phone	Work Phone	Cell Phone	Relationship
Address				

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Current Primary Physician Name	Address	Phone Number
Current Specialist	Address	Phone Number
Current Dentist	Address	Phone Number
Preferred Hospital	Address	Phone Number

MEDICAL INFORMATION

LIST ALL CURRENT MEDICATIONS TAKEN

Medication	Dose	Route (by mouth, g-tube, etc.)	Time	Reason

RELEVANT EMERGENCY MEDICAL INFORMATION (include special medical or personal information you want emergency care provider(s) to know.

Medical (include all diagnoses, surgical history, medical problems)

Signature of Person Completing Form

_____ Date _____

Signature of Legal Guardian

_____ Date _____

Co-Legal Guardian (If Applicable)

_____ Date_____