

## Current Status of Sensory & Ability Information

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**Vision:** Last date tested: \_\_\_\_\_ By whom: \_\_\_\_\_  
Where: \_\_\_\_\_ Results if known: \_\_\_\_\_  
\_\_Glasses \_\_Contact lens \_\_Prosthesis \_\_Other \_\_\_\_\_

**Hearing:** Last date tested: \_\_\_\_\_ By whom: \_\_\_\_\_  
Where: \_\_\_\_\_ Results if known: \_\_\_\_\_  
\_\_Wears aids \_\_Right ear \_\_Left ear \_\_Both ears

### Mobility/Orthotics:

\_\_Braces: Type: \_\_\_\_\_ Orthotist: \_\_\_\_\_ Provided by: \_\_\_\_\_  
\_\_Wheelchair: Type: \_\_\_\_\_ Orthotist: \_\_\_\_\_  
Provided by: \_\_\_\_\_ Measured by: \_\_\_\_\_  
Date last measured: \_\_\_\_\_  
\_\_Walker: Type: \_\_\_\_\_ Orthotist: \_\_\_\_\_ Provided by: \_\_\_\_\_  
\_\_Jacket: Type: \_\_\_\_\_ Orthotist: \_\_\_\_\_ Provided by: \_\_\_\_\_

### Communication:

\_\_Computer \_\_Communication Board \_\_Lip reads  
\_\_Sign Language (ASL) \_\_Sign Language (English) \_\_Interpreter Services  
\_\_Communication book \_\_Other

### Developmental Screening:

At what age is child functioning: cognitively \_\_\_\_\_ Motor skills \_\_\_\_\_  
Date tested \_\_\_\_\_ By whom \_\_\_\_\_ Where \_\_\_\_\_

### Ambulation:

\_\_Walks independently \_\_Walks with assistance  
\_\_Walks with walker/brace \_\_Non-ambulatory  
\_\_Uses wheelchair with assist. \_\_Motorized  
\_\_Uses wheelchair w/o assist. \_\_Motorized

### Transfer Directions:

\_\_Independent \_\_With Assist \_\_Equipment type \_\_\_\_\_  
\_\_Pivot Transfer \_\_1 or 2 person lift \_\_Other \_\_\_\_\_

### Feeding:

\_\_Regular diet \_\_Soft diet \_\_Pureed \_\_Finger foods  
\_\_No assist. \_\_Partial assist. \_\_Total assist. \_\_Feeding pump  
\_\_Special dishes or utensils

**Special Diet/Instructions**

     **Not applicable to my child**

Type	Route	Amount/Schedule	Start Date

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Hygiene:**

     No assistance         Partial assistance         Totally assisted         Bath chair or shower equipment

**Toileting:**

     Fully toilet trained         Diaper at night         Diaper dependent         No assistance

     Partial assistance         Full assistance

     Intermittent catheterization program

Frequency \_\_\_\_\_ Technique \_\_\_\_\_

     Independent         Needs assistance

     Bowel management program

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_