

## Status and Needs Communication System (SYNCS): A New Tool for Enhancing Communication in Intellectual/Developmental Disability (IDD) Services

<b>Member Information:</b>	
* Member's Full Name: _____	
* Member's MA (Medicaid ID) :	* Member's Date of Birth (MM/DD/YYYY) :
Member's Diagnosis (ICD-10 code (s) and diagnosis name (s):	
<p><b><u>Please to be sure to attach/include the following:</u></b></p> <p><input type="checkbox"/> Current medication list</p> <p><input type="checkbox"/> Copy of MAR</p> <p><input type="checkbox"/> Copy of IEP and/or ISP</p> <p><input type="checkbox"/> Contact List (should include pharmacy, PCP, behavior consultant or therapist, psychiatrist, and other providers)</p>	

<b>Prior Hospitalizations:</b>	<b>Team Contact Information:</b>
Please indicate timeframe for prior hospitalization:  <input type="checkbox"/> Never before been hospitalized <input type="checkbox"/> Within the last month <input type="checkbox"/> Within the last quarter <input type="checkbox"/> Within the last 6 months <input type="checkbox"/> A year or more <input type="checkbox"/> Unknown	<u>Outpatient Psychiatrist Name:</u> Phone Number:   <u>Clinical Point of Contact:</u> Phone Number:

<b>Presenting Symptoms/Behaviors:</b>
What are the current symptoms and behaviors? What is a "normal"/"good day" for this individual? _____ _____ _____

<b>Changes in Mental Health behavior:</b>	
Please note all mental health behavior <b><u>CHANGES</u></b> :	
<b>Depressive Symptoms (not going out as often, isolating)</b> <input type="checkbox"/> Yes <input type="checkbox"/> No How long has this been occurring (i.e. hourly, daily or weekly): _____	<b>Manic Symptoms (overly excited, having lots of energy)</b> <input type="checkbox"/> Yes <input type="checkbox"/> No How long has this been occurring (i.e. hourly, daily or weekly): _____
<b>Delusional Symptoms (believing things that are not real)</b> <input type="checkbox"/> Yes <input type="checkbox"/> No How long has this been occurring (i.e. hourly, daily or weekly): _____	<b>Hallucinations (seeing/hearing things others do not)</b> <input type="checkbox"/> Yes <input type="checkbox"/> No How long has this been occurring (i.e. hourly, daily or weekly): _____

<p><b>Self-Harm (hurting oneself on purpose)</b></p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p> <p>How long has this been occurring (i.e. hourly, daily or weekly):</p> <p><b>Anxiety Symptoms (feeling very worried or nervous)</b></p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p> <p>How long has this been occurring (i.e. hourly, daily or weekly):</p>	<p><b>Intent to Harm Others (aggression/homicidal ideation)</b></p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p> <p>How long has this been occurring (i.e. hourly, daily or weekly):</p>
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<p><b>Medical Changes:</b></p> <p><b>Please note all medical <u>CHANGES</u>:</b></p> <p> <input type="checkbox"/> Sleep:      <input type="checkbox"/> Increased      <input type="checkbox"/> Decreased  <input type="checkbox"/> Appetite:   <input type="checkbox"/> Increased      <input type="checkbox"/> Decreased  <input type="checkbox"/> Toileting  <input type="checkbox"/> Medication  <input type="checkbox"/> Dental  <input type="checkbox"/> Pain  <input type="checkbox"/> Other (please describe):         </p>	<p><b>Environmental Factors:</b></p> <p><b>Please note all environmental <u>CHANGES</u>:</b></p> <p> <input type="checkbox"/> Loss of a family member, peer, or other  <input type="checkbox"/> Change in home location  <input type="checkbox"/> Change in staff or housemate  <input type="checkbox"/> Other         </p> <hr style="border: 0; border-top: 1px solid black; margin-top: 10px;"/>
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<p><b>Additional Information:</b></p> <p>What is current home environment (i.e. staffing level, number of housemates)?</p> <hr style="border: 0; border-top: 1px solid black; margin-bottom: 10px;"/> <hr style="border: 0; border-top: 1px solid black; margin-bottom: 10px;"/> <p>Please list current coping skills and/or special preferences and interests. Please include any information about how best to care for the individual.</p> <hr style="border: 0; border-top: 1px solid black; margin-bottom: 10px;"/> <hr style="border: 0; border-top: 1px solid black; margin-bottom: 10px;"/> <hr style="border: 0; border-top: 1px solid black; margin-bottom: 10px;"/> <p>What is communication method (check all that apply)?</p> <p> <input type="checkbox"/> Visuals   <input type="checkbox"/> Written   <input type="checkbox"/> Technology   <input type="checkbox"/> Gestures   <input type="checkbox"/> Other         </p>
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