Supported Lifestyles
MONTHLY SUMMARY

Individual's Name: _____ Month _____ Year: _____

Report written by: _____ Reviewed by: _____

Date received @ office: _____ Service Area: ☐Career ☐Residential ☐Res/Career ☐Progressive Residential

1. PRESENT SCHEDULE

Weekly Plan

Fill in the actual activities as applicable for each week of the month. If the schedule is highly structured and does not change, check the box and only fill out one week of activities.

☐ **Activities are structured and do not change from week to week.**

WEEK 1

TIME	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
AM							
PM							

WEEK 2

TIME	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
AM							
PM							

WEEK 3

TIME	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
AM							
PM							

WEEK 4

TIME	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
AM							
PM							

****Note: Should you need more space for any section, use a separate piece of paper, numbering the sections and attach to the back of the monthly summary.**

2. INDIVIDUAL'S SOCIAL CONTACTS (Include dates, activities, etc.):

Y N

☐ ☐ **Family**_____

_____

☐ ☐ **Friends**_____

_____

☐ ☐ **Other (Specify)**_____

_____

3. INDIVIDUAL'S PROFESSIONAL CONTACTS (Include dates):

Y N

☐ ☐ **Psychiatrist**_____

_____

☐ ☐ **Physician**_____

_____

☐ ☐ **Guardian**_____

_____

☐ ☐ **Team Meetings**_____

_____

☐ ☐ **Other (Specify)**_____

_____

4. INDIVIDUAL'S PHYSICAL HEALTH (Comment on significant changes in lifestyle habits, smoking, drinking, appetite, sleep, weight, self-care, seizure patterns):

_____

_____

_____

_____

5. NEW MEDICATION OR MEDICATON CHANGES:

_____

_____

_____

_____

WERE ANY PRN MEDICATION ADMINISTERED IN THE MONTH ☐ **YES** ☐ **NO**

If 'YES', list the PRN's administered and complete the chart:

NAME OF MEDICATION	DOSAGE	REASON GIVEN	DATES GIVEN	OBSERVED OUTCOME

6. APPROVED POSITIVE APPROACHES AND RESTRICTIVE PROCEDURES USED:

Refer to the "INTERPERSONAL AND EMOTIONAL SUPPORT" section of the profile for approved procedures. Please ensure that the behaviors listed here match those in the individual's profile. Contact your supervisor for a summary that is specific to this individual if necessary.

Behavior of Concern (include # OF TIMES OBSERVED)	Pos. Approach Used	Effective (#)		Restrictive Used (include date used)	Effective (#)	
		Y	N		Y	N

***NOTE: Please use APPENDIX (at back of summary) for additional space for above table if needed.**

NEW BEHAVIORS OF CONCERN: Please identify all Positive Approaches and Emergency Restrictive Procedures used to address the new Behavior of Concern. **An Incident Report must have been completed to document any Emergency Restrictives used.**

NEW BEHAVIORS OF CONCERN (INCLUDE # OF TIMES OBSERVED)	POS. APPROACH USED (BRIEFLY DESCRIBE)	Effective		RESTRICTIVE USED (BRIEFLY DESCRIBE)	Effective	
		Y	N		Y	N
		☐	☐		☐	☐
		☐	☐		☐	☐
		☐	☐		☐	☐

7. INDIVIDUAL'S HIGHLIGHTS OF THE MONTH (Significant events, successes, trends or changes). Comment on anything positive about the individual you are supporting:

8. LIST INDIVIDUAL LIFESTYLE PLAN GOALS (FROM THEIR LSP) & COMMENT ON PROGRESS:

Goal:

Goal:

Goal:

Goal:

9. SUMMARIZE ANY FEEDBACK FROM THE INDIVIDUAL ABOUT THEIR PLAN:

10. FINANCIAL: RECORD THE AMOUNT OF MONEY THE INDIVIDUAL EARNED AND WHO RECEIVES THIS INFORMATION:

Work Placement: _____

Amount Earned: _____ **Information sent to** ☐**AISH** ☐**Trustee** ☐**Residential Provider**

Work Placement: _____

Amount Earned: _____ **Information sent to** ☐**AISH** ☐**Trustee** ☐**Residential Provider**

11. ITEMS FOR TEAM FOLLOW-UP DISCUSSIONS:

12. HEALTH AND SAFETY CONCERNS (Comment on risks encountered with the individual):

Community First Aid kit checked (for Career Services): ☐**Yes - Supervisor's initials: _____** ☐**N/A**

13. REVIEWER FEEDBACK/COMMENTS:

DATE SENT:_____ COPY SENT TO: ☐**Individual/Guardian** ☐**Supervisor** ☐**Support Approach Consultant**