DD Resident Record Books – Table of Contents

Part One: Resident Information

- Resident Information Sheet (with up-to-date emergency contact information)
- End of Life Documentation (e.g. POLST, Advance Directive, DNR)
- Letter of Guardianship if applicable
- Letter of Conservatorship if applicable

Part Two: ISP, Protocols and Behavioral Support

- Current, complete, signed Individual Support Plan (ISP)
- Functional Assessment/Behavior Support Plan if applicable
- Exception Request for Out-of-Class Resident if needed

Part Three: Medical Information

- **NOTE: Current MARs, Physician Orders, and PRN Guidelines, Controlled Medication Count Sheets, and Drug Disposal Sheets are kept in the home's separate MAR binder**
- Protocols if applicable (seizure, constipation, etc.)
- Nursing Delegations if needed
- Nurse and Healthcare Professional Notes
- Older MARs, Physician Orders, PRN Guidelines, Controlled Substance & Drug Disposal for Past 6-12 Months
- Approved Restraints, if needed
- Balancing Test (past 7 years, if applicable)

Part Four: Admission Information

- Screening Form (Initial & Readmission from Hospital Stay)
- Interagency Exception Placement Form, if needed
- Signed Residents' Bill of Rights
- Signed Residency Agreement
- Personal Possession Inventory Record
- Authorization for Release of Information (ROI)

Part Five: Progress Notes and Tracking

- DD Incident Report
- Progress Notes
- Activity Log
- Individual Financial Records (tracking), if needed

Note: Maintain a readable and accessible Resident Record by archiving older information to a separate location.