

PART II: EQUIPMENT

Section A: Wheelchair Checklist

D.S.R.P RECOMMENDS:

- New wheelchair batteries (if your current batteries are 9 months old or older)
- New tires with "solid inserts" front and rear
- Good restraint/seatbelt system
- Basic wheelchair repair kit
- Extra parts that you know you will need to repair your chair
- If you are using a brand-new power chair, or if you do not have much practical experience driving your power chair, please practice your driving skills
- Berkeley is full of hills, and we strongly recommend that you use a power chair
- Bring owner's manual, maintenance manuals, maintenance records, and other important documents about your wheelchair with you. Also, the name, address, and telephone number(s) of the person(s) who has serviced your wheelchairs
- Make an appointment with one of the local wheelchair facilities. Please see list of local providers on the yellow sheet in this packet.

What type of wheel chair(s) do you use?

1. Motorized: Yes/No

If Yes, What is the brand name/make/model of the chair? _____

How do you operate/drive your wheelchair?

Head Control _____

Joystick _____

Foot Plate Control _____

Other _____ (Explain: _____)

Does it tilt or recline? Yes/No

Do you use any misc. equipment with your power chair? Yes/No

If yes, what type of misc. equipment is powered by your chair? _____

2. Manual: Yes/No

If Yes, What is the brand name/make/model of your chair? _____

Can you operate your manual chair? _____

Does it tilt or recline? Yes/No

Section B Respiratory Aids:

Do you use respiratory aids? Yes/No

If yes, please specify the type(s), make(s) and model(s): _____

What periods of the day do you use it?

K. Do you have a tracheotomy tube that assists you with breathing? Yes/No
If yes, how long have you had it? _____

L. Do you require suctioning? Yes/No
If yes, how often? _____

Also please tell us the type/make/model and year of the suctioning device:

Is the device portable? Yes/No

Section C: Personal Care Routine Items:

Do you use a sliding board? Yes/No
Shower Chair? Yes/No
Commode Chair? Yes/No
Raised Toilet Seat? Yes/No
Walker? Yes/No
Braces. Leg/Hand? Yes/No
Other? Please Specify _____

Section D: Bed

Will you be bringing your own bed? Yes/No If yes please specify below.

Hospital (manual) Yes/No

Hospital (electric) Yes/No

Standard Bed Twin/Full

Other : _____

Of the equipment discussed in Part II, are you in the process of replacing your equipment before you arrive? Yes/No

If yes, what are you replacing?

PART III: COMMUNICATION SYSTEMS

This section will also assist D.S.R.P. in setting up your phone line mentioned in the attached letter.

Are you able to use the phone from bed? Yes/No

Do you have a phone line in your own name? Yes/No

What type of telephone can you operate by yourself?

Dial? Yes/No Touch? Yes/No TDD? Yes/No Other? Yes/No

(Please explain) _____

What special services do you currently use from the phone company?

(Example: operator-assisted (“manual service” in California))

Do you wish to have your phone number unlisted in the Pacific Bell directory? Yes/No

Please note you will need to pick a long distance carrier when you arrive. Also please note there is a charge for setting up the phone lines. Please see the “Cost of Attendance” attached.

How do you communicate?

Verbal? Yes/No

Communication Device/Head or Board? Yes/No

If yes, please Explain: _____

Other? Yes/No

If yes, please Explain: _____

Do you type? Yes/No

Write Longhand? Yes/No

Dictate? Yes/No

Sign your name? Yes/No

PART IV: COMPUTERS

What type of computer do you have? Macintosh:_____ Windows 95/98:_____ Windows NT:_____ Other_____ (Please explain)_____

Portability of your computer: Laptop:_____ Desktop/Tower:_____

What types of software are on your computer?

Functions:	Software (specify Version): (i.e. Netscape Communicator version 4.7)
E-mail	_____
Web Access	_____
Word processing/Office Suite	_____
Specialized Software	_____
Other	_____

How do you control your computer?

Typing:	Pointer:
_____ Standard Keyboard	_____ Standard Mouse
_____ Ergonomic keyboard	_____ Track Ball/Touch Pad
_____ Voice Recognition	_____ Voice Recognition
_____ On Screen	_____ Laser/head pointer
_____ Other (Please explain) _____	_____ Other (Please explain)
_____	_____

PART V: DAILY ROUTINE

In order for the Attendant Referral Office and Special Assistants to serve your needs when you arrive in Berkeley, please take a moment to answer the following. Feel free to contact us for clarification on any of the questions.

ATTENDANT CARE:

Have you had experience hiring attendants? Yes ____ No ____

Who is assisting you at the present time? _____

How long does your a.m. routine take? _____

How long does your p.m. routine take? _____

What transfer type (s) do you use?

Pivot _____

Pivot while YOU bear some/all weight _____

Cradle Lift _____

Hoyer _____

Two-person transfer _____

Do you need assistance with meals? Yes ____ No _____

Cutting up food? Yes _____ No _____

Do you need any assistance feeding yourself? Yes _____ No _____

If Yes, How long does it take you to eat a meal? _____

PLEASE CHECK AREAS THAT YOU WILL NEED ASSISTANCE WITH:

Personal Hygiene:

_____ Showering/bathing

_____ Hair washing/combing

_____ Brushing teeth/flossing

_____ Dressing/undressing

_____ Shaving

_____ Cosmetic application

_____ Skin medication

Bladder Care

_____ External (Condom)

_____ Internal (Urethral)

_____ Intermittent catheterization

_____ Urinal (Hand Held)

_____ Suprapubic

Bowel Care:

_____ Toilet transfer

_____ Suppository

_____ Digital stimulation

_____ Colostomy

_____ Ileostomy

Do you need to be repositioned at night? Yes/No

If yes, how often? _____

Do you have recurring problems with any of the following? (If so, please explain)

Eating and or hydration? Yes/No

If yes, please specify: _____

Do you use a gastrointestinal tube for any of your eating and/or hydration? Yes/No

If yes, please Explain _____

Skin (including pressure sores) Yes/No

If yes, please Explain _____

Blood Pressure? Yes/No

If yes, please Explain _____

Is sweating or high blood pressure relating to disreflexia a problem for you? Yes/No

If yes, please Explain _____

Other? Yes/No

If yes, please Explain _____

Do you have any allergies?

Latex Yes/No

Food Yes/No

Medication Yes/ No

Other (Explain Below)

If yes, Please Explain

Do you have seizures? Yes/No

If yes, please explain the type of seizure and what should be done during and after your seizure.

PART VII: FINANCIAL RESOURCES

Do you receive assistance from any of the following programs?

Supplementary Security Income (SSI): Yes___ No___ Currently Applying___
Social Security Disability Insurance. (SSDI): Yes___ No___ Currently Applying___
Student Financial Aid for next year: Yes___ No___ Currently Applying___
In-Home Support Services. (IHSS): Yes___ No___ Currently Applying___

Name, address & phone of your IHSS Social Worker:

Department of Rehabilitation. (DR): Yes___ No___ Currently Applying___

Name, address & phone of your DR counselor:

Where have you lived since onset of disability? (Rehab. center, home, etc.)

What is your present living situation?

Please complete the following section on a separate sheet. This page should be typed and submitted when you send the "Information Please" document.

Please let us know the specific detailed steps in your Morning and Evening routines. First, list the steps in CHRONOLOGICAL order for your morning and evening routine. Please include details of every single action of your routine process(es) and include the time each action should take.

Example:

Bowel program, position on left side, insert suppository, after 5 minutes pivot transfer to shower chair etc...

PART VIII: INDEPENDENCE PERSPECTIVE

(Please use a separate piece of paper to answer the following questions. Each answer should be no more than 1 page.)

1. What are your expectations and hopes for being a part of the Disabled Students Residence Program?
2. What areas do you feel an independence-oriented program such as ours will help you develop?
3. What strengths do you have that will help you embrace independent living?
4. What areas do feel that you need support in to help you embrace independent living?

Thanks for taking the time to fill this out. We hope to use all of this information in planning for your arrival in Berkeley. If there is anything else you can think of that would be of help to us in making these preparations, please add the information or suggestions on the back of this page. Please let me know if you would like this form sent to you on email. Also, please feel free to call or email me with any questions about this form.

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