Washington State
Department of Social
& Health Services
Transforming lives

DEVELOPMENTAL DISABILITIES ADMINISTRATION (DDA)
DDA Nursing Service Referral

1. REFERRED TO AGENCY / NURSE	2. TELEPHONE NUMBER	DATE OF REFERRAL

FAX NUMBER	EMAIL ADDRESS (EXCLUDING AAA)	AUTHORIZATION NUMBER

3. CLIENT NAME (LAST, FIRST, MI)	DATE OF BIRTH	TELEPHONE NUMBER (INCLUDE AREA CODE)

ACES ID NUMBER	PROVIDER ONE NUMBER

CLIENT'S PRIMARY DIAGNOSES RELATED TO REFERRAL REASON

4. CLIENT ADDRESS	CITY	STATE	ZIP CODE

5. ALTERNATIVE CONTACT, IF CLIENT IS UNREACHABLE (LAST, FIRST)	6. RELATIONSHIP TO CLIENT	TELEPHONE NUMBER

7. LEGAL REPRESENTATIVE NAME (IF ANY)	TELEPHONE NUMBER

Referral Request

10. Requested Activity (check all that apply)

☐ Nursing Assessment / Reassessment (visit)
☐ Instruction to client and/or Providers (visit)
☐ Resource Coordination
☐ Skin Observation Protocol (visit required)

☐ Other:

11. Activity Frequency (days / week times per week / month / year)

Frequency Duration of Activity:
Frequency Duration of Activity:
Frequency Duration of Activity:
Frequency Duration of Activity:
Assessment due by:
Frequency Duration of Activity:

12. CARE Nursing-Related Triggered Referral Reason (Check all that apply)

☐ Unstable / potentially unstable diagnosis
☐ Medication regimen affecting plan of care
☐ Nutritional status affecting plan of care
☐ Immobility issues affecting plan of care

☐ Current or potential skin problem (not SOP)
☐ Skin Observation Protocol
☐ Other reason:

13. SPECIAL INSTRUCTIONS

☐ Requesting visit be made with case manager
☐ Consult with case manager before contacting client or caregiver
☐ Request visit with caregiver
☐ Interpreter Required for   language

☐ Additional Comments:

14. CASE MANAGER	E-MAIL ADDRESS	FAX NUMBER

CASE MANAGER TELEPHONE NUMBER or 1-800-	DATE

IMPORTANT: **Send referral via secure fax / email, including applicable assessments / plans: DDA Assessment Details, Individual Support Plan, Behavioral Support Plan, Services Summary, Consent, and a copy of all nursing-related triggered referrals including CARE elements.**

Notes: If you are referring a client enrolled in Home and Community Services, use DSHS form 13-776.

Confirmation of Receipt and Acceptance of referral by Nursing Services Provider

☐ Referral received   Date Received: ☐ Additional Comments:

☐ Referral accepted

☐ Referral not accepted

Reason:

☐ Nurse Assigned:

    Telephone Number:

Instructions for Completing DDA Nursing Service Referral

The Nursing Services Referral is completed for initiation of a referral to Nursing Services provided for Developmental Disabilities Administration or Children's Administration clients. This form is completed by the case manager and sent to the contracted Nursing Services provider (Area Agency on Aging, contracted agency or contracted individual RN). This form should be completed each time a new referral request for nursing services is being established for a client.

1. **Referred To:** Enter the name of the Area Agency on Aging, contracted agency or contracted Nurse Consultant.

2. **DSHS Office:** Enter the name of the Developmental Disabilities Administration or Children's Administration office.

3. **Client Name:** Enter the client's name, date of birth, telephone number and client ProviderOne number. Include authorization number, client diagnosis and check appropriate attachment.

4. **Client Address:** Enter the address where the client is residing, and would receive services.

5. **Caregiver Name:** Enter the caregiver name. If the client has multiple caregivers, enter the name of the primary caregiver for the client. Enter the telephone number of the caregiver.

6. **Agency Name:** Enter the name of the Home Care Agency as needed. Enter the telephone number of the Home Care Agency.

7. **Contact Name:** Enter any contact name information if different than the caregiver.

8. **Contact Relationship to Client:** Enter the relationship of the contact name to the client (e.g. parent, sibling, friend).

9. **Guardian Name and Telephone Number:** Enter the guardian name and telephone number as appropriate.

10. **Referral Request:** The case manager checks all of the nursing services requested for the client, indicating the type of activity if SOP refer to DDA Policy 9.13.

11. **Requested Activity Frequency:** Enter the frequency and duration of the activity requested (e.g. once a month for six months, once a week for two weeks, one time only).

12. **Reason for Request:** Enter the Nursing Referral Indicator(s) or other reason the client is being referred for Nursing Services.

13. **Special Instructions:** Enter any special instructions for this Nursing Services referral. This includes number of additional visit requested by the nurse / nursing agency and any additional comments as needed.

14. **SW / Case Resource Manager:** The referrer completes this information with the case manager name and contact information.

Confirmation of Receipt and Acceptance of Referral by Nursing Services Provider

The receiving Nursing Services provider completes the section to indicate to the referral source the receipt and acceptance of the referral to provide the requested nursing activity. The referral form is sent back to the referral source with the following information completed within two working days.

Referral Received: Enter the date the referral was received.
Referral Accepted: Check this box if the referral is accepted and the provider is able to provide the requested nursing services activities.
Referral Not Accepted: Check this box if the referral is not able to be accepted, and the provider is unable to provide the requested activities.
Nurse Assigned: Enter the name of the nurse and contact information (telephone, office and e-mail as needed).
Additional Comments: The Provider enters any additional comments needed for the referent.