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| Transforming Lives | DEVELOPMENTAL DISABILITIES ADMINISTRATION (DDA)  **DDA Diversion Services Referral**  **and Intake Information** | | | | | |
| CLIENT’S FULL NAME | | | | DATE OF BIRTH | | ADSA NUMBER |
| NAME OF PERSON MAKING REFERRAL | | TELEPHONE NUMBER | | DCR  DDA | OTHER: | |
| DDA CASE MANAGER | | | | DDA CM TELEPHONE NUMBER | | |
| RESIDENTIAL AGENCY PROVIDER | | | | PROVIDER TELEPHONE NUMBER | | |
| FAMILY / LEGAL REPRESENTATIVE | | | | REPRESENTATIVE TELEPHONE NUMBER | | |
| Medicaid  Medicare  Medicare Part D Provider: | | | OTHER INSURANCE: | | | PROVIDERONE ID |
| Current Housing Situation | | | | | | |

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| Communication Style (nonverbal/verbal, primary language, preferred modes): |

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| Diagnosis: |

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| Briefly describe why this person is being referred. List current symptoms / behaviors of concern (define and state frequency and severity of each symptom/behavior). |

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| History of Violent / Dangerous Behaviors and No Contact Orders: |

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| Is this individual a Community Protection Participant?  Yes  No |

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| History of Fire-Setting: |

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| History of Sexual Abuse/Assault: |

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| History of Substance Abuse: |

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| History of Vandalism/Destructive Behavior: |

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| Legal History (DOC, jail, mental health commitments, chemical dependency commitments): |

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| Is person on a Court Order or LRA?  Yes  No | NAME OF CORRECTIONS OFFICER OR LRA MONITORING AGENCY | TELEPHONE NUMBER |
| Previous Mental Health Involvement: | | |

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| Describe all known allergies: |

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| Describe all Known Physical and Medical Issues: |

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| Describe all Known Medical or Mental Health Treatments Needed: |

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| CURRENT PRIMARY CARE PHYSICIAN | TELEPHONE NUMBER |
| CURRENT MH PRESCRIBER | TELEPHONE NUMBER |
| Is the person ambulatory?  Yes  No  Does the person use a prosthetic device?  Yes  No  If yes, describe: | |
| Is the person willing to take medications as prescribed?  Yes  No  Date of last medication review:  Is nurse delegation needed?  Yes  No If yes, nurse delegation records must be included in the referral. | |
| Known Appointments Scheduled (who / where / when): | |

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| Treatment Plan / Goals for the Person Receiving Diversion Services: |

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| Client Financial Resource Information (optional for mobile diversion): |

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| Other important information: |

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| Discharge Plans: |

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| Hobbies / Interests:    Favorite Foods:    Favorite Places:    Dislikes: | | |
| Information Checklist (documents to be included as appropriate):  Signed Physician’s Orders (durable medical equipment, medication, and nurse delegation orders, etc.)  Cross System Crisis Plan  Functional Assessment  Positive Behavior Support Plan  Individual Instruction and Support Plan (IISP)  DDA Assessment Details  Psychiatric / Psychological Evaluations  Community Protection Treatment Plan and Current Risk Assessment  Guardianship Documentation  Current Medication Record  Other (specify): | | |
| SIGNATURE OF PERSON COMPLETING FORM | TITLE | DATE |
| **TO BE FILLED OUT BY CRISIS DIVERSION BED PROVIDER** | | |
| Referred for:  Bed-based  Mobile  Who is transporting the person? | Person accepted?  Yes  No  Who is transporting the person? | |
| PROVIDER SIGNATURE | TITLE | DATE |