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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 **[ ]**  NoDoes the person use a prosthetic device? **[ ]**  Yes **[ ]**  NoIf yes, describe:  |
| Is the person willing to take medications as prescribed? **[ ]**  Yes **[ ]**  NoDate 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 **[ ]**  MobileWho is transporting the person?  | Person accepted? **[ ]**  Yes **[ ]**  NoWho is transporting the person?  |
| PROVIDER SIGNATURE | TITLE | DATE |