



**Massachusetts Department of Developmental Services
Aging and Developmental Disabilities Consultation Program**

New Patient Referral Request

Thank you for your interest in the Aging and Developmental Disabilities Program, a consultative service provided to clients of the Department of Developmental Services of Massachusetts.

Consultations are provided by Julie Moran, D.O., a board certified internist and geriatrician who specializes in adults with intellectual and developmental disabilities.

Consult requests and intake forms will only be accepted from the DDS Area Office Nurse. Forms must be fully completed before an appointment will be scheduled.

*Please also ensure that guardians have been notified, when applicable.

If you are interested in being seen at the **Worcester location (324 Clark Street, Worcester, MA)**, please send your completed form via secure DDS email to Lisa A. Cobb at: lisa.cobb@massmail.state.ma.us or by fax to: 508-792-7226

If you are interested in being seen at the **Tewksbury location (Tewksbury Hospital, 365 East Street, Tewksbury, MA)**, please send your completed form via secure DDS email to Kim Dale, RN, CDDN at: kim.dale@massmail.state.ma.us or by fax to: 978-863-2234

Thank you! We look forward to working with you.

Patient Information			
Name			
Date of birth			
Street Address			
Town/Zip			
Sex			
Department of Developmental Services referral information:			
DDS Area Office Nurse			
DDS Service Coordinator			
Area Office Location			
Contact phone numbers	Cell:		
	Office:		
Email address			
Guardianship information (if applicable)			
Legal Guardian Name			
Mailing Address			
Town/State/Zip			
Phone number			
Appointment booking information			
Primary contact person <i>(**individual typically responsible for booking appointments)</i>			
Relationship to patient			
Phone number			
Email address			
May we email you with appointment information?	<input type="checkbox"/>	Yes	<input type="checkbox"/> No
Primary Care Provider			
PCP Name			
Street Address			
Town/Zip			
Phone Number			
Other Relevant Specialists			
Psychiatrist's Name <i>(if applicable)</i>			
Street Address			
Town/Zip			
Neurologist's Name <i>(if applicable)</i>			
Street Address			
Town/Zip			

Family History		
<input type="checkbox"/> Intellectual/developmental disability	<input type="checkbox"/> Mental Illness	<input type="checkbox"/> Stroke
<input type="checkbox"/> Dementia	<input type="checkbox"/> Heart disease	<input type="checkbox"/> Other: (specify)
Review of Systems		
Vision <input type="checkbox"/> low vision <input type="checkbox"/> wears glasses <input type="checkbox"/> cataracts Last eye doctor exam:	Weight: <input type="checkbox"/> stable <input type="checkbox"/> recent weight gain <input type="checkbox"/> recent weight loss	
Hearing <input type="checkbox"/> hard of hearing <input type="checkbox"/> wears hearing aids Last audiology testing:	Appetite: <input type="checkbox"/> stable <input type="checkbox"/> poor/diminished <input type="checkbox"/> increased	
Dental <input type="checkbox"/> decay/missing teeth <input type="checkbox"/> wears dentures <input type="checkbox"/> no teeth Last dental visit:	Swallowing: <input type="checkbox"/> no issues <input type="checkbox"/> dysphagia/swallow dysfunction <input type="checkbox"/> Requires modified diet <input type="checkbox"/> requires pacing/supervision	
Seizures <input type="checkbox"/> history of seizures <input type="checkbox"/> concern for possible seizure activity	Sleep: <input type="checkbox"/> stable <input type="checkbox"/> insomnia <input type="checkbox"/> fragmented sleep <input type="checkbox"/> frequent daytime napping <input type="checkbox"/> snoring <input type="checkbox"/> sleep disorder	
Incontinence: <input type="checkbox"/> none <input type="checkbox"/> urinary <input type="checkbox"/> fecal	Pain: <input type="checkbox"/> none reported <input type="checkbox"/> pain suspected <input type="checkbox"/> pain reported Is the patient a reliable reporter of pain? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Walking: <input type="checkbox"/> steady <input type="checkbox"/> unsteady <input type="checkbox"/> depth perception difficulties <input type="checkbox"/> Requires assistive device <input type="checkbox"/> recent falls	History of head injury? <input type="checkbox"/> No <input type="checkbox"/> h/o concussion <input type="checkbox"/> h/o traumatic injury <input type="checkbox"/> repeated self injury involving head	
Other:		
Social History		
Living situation:	<input type="checkbox"/> supported community living <input type="checkbox"/> lives with family <input type="checkbox"/> community residence <input type="checkbox"/> adult foster care	<input type="checkbox"/> shared living <input type="checkbox"/> nursing home <input type="checkbox"/> other (please specify):
Level of supports at home:	<input type="checkbox"/> 24 hour supervision <input type="checkbox"/> With awake overnight staff <input type="checkbox"/> With asleep overnight staff <input type="checkbox"/> Case management	<input type="checkbox"/> PCA or home health aide <input type="checkbox"/> Program nurse <input type="checkbox"/> Visiting nurse <input type="checkbox"/> Homemaker <input type="checkbox"/> Respite
Employment/Day Program	<input type="checkbox"/> Community-based employment <input type="checkbox"/> Vocational/ employment program <input type="checkbox"/> Day program	<input type="checkbox"/> Day habilitation <input type="checkbox"/> Home based programming <input type="checkbox"/> None
Marital Status	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced/separated <input type="checkbox"/> Widowed	
Habits	<input type="checkbox"/> Tobacco use <input type="checkbox"/> Former <input type="checkbox"/> Current	<input type="checkbox"/> Alcohol use <input type="checkbox"/> Former <input type="checkbox"/> Current
<input type="checkbox"/> Drug use <input type="checkbox"/> Former <input type="checkbox"/> Current		
Any additional comments:		

BASELINE Abilities and Characteristics

Below, please describe the individual's abilities that **were typical of what they could do throughout adulthood at their very best**. Please note, this section is for **baseline** characteristics. In the following section, there will be room to describe the ways in which these may have changed in recent years, if applicable. Please respond as concisely but thoroughly as possible -

<p>Function</p>	<p>Please describe: How independent was the individual in performing self care tasks throughout lifetime? Bathing, dressing, toileting, grooming, eating, and walking? Has there always been need for assistance? How much?</p>
<p>Skills</p>	<p>Please describe: How far did the individual go in school? What academic skills were achieved? What chores or responsibilities was the individual capable of around the house? Employment? Day program? What would he/she do there? Any other talents or abilities throughout lifetime?</p>
<p>Memory</p>	<p>Please describe: Could the individual learn and use names of familiar people? Keep track of the day of the week? Keep track of a daily or weekly schedule? Knew the date? Could keep track of recurring events? Knew his/her way around familiar areas? Could he/she reliably remember short term information, such as an upcoming doctor's visit? Could they reliably recall recent past events, such as what they ate for lunch, who they saw yesterday? Any particular memory talents?</p>
<p>Behavior</p>	<p>Please describe: What behaviors have been present throughout adulthood? Self injurious behaviors? Aggression towards others, either verbal or physical? Has the individual required a behavior plan? If so, what did this consist of? Any other typical pattern or triggers to behaviors over lifetime?</p>
<p>Language</p>	<p>Please describe: Can the individual express him/herself verbally? Can he/she let their basic needs and wants be known? Speak in full sentences? Hold a conversation? Are there other forms of communication - ie; signs, gestures, etc. Could the individual understand verbal language? Answer questions appropriately or follow a verbal instruction?</p>
<p>Personality</p>	<p>Please describe: Did the individual seek out peer relationships? Was he/she social? Liked by others? Did he/she have particular personality quirks throughout lifetime, ie; stubbornness, resistance/intolerance to change in routine, etc.</p>
<p>Mood</p>	<p>Please describe: What was the individual's mood like most days? Were there mood swings? Were there mood/psychiatric issues that recurred or persisted throughout adulthood? Please describe.</p>

CURRENT Abilities and Characteristics

*Below, please describe the individual's **current abilities** - highlighting, when applicable, the areas in which changes are **noted** compared to what was described above in the baseline section. Again, please be concise but thorough.*

Function	<i>Please describe: Lately, how independent is the individual in performing self care tasks? Bathing, dressing, toileting, grooming, eating, and walking? Have changes been observed in functional abilities compared to baseline, described above?</i>
Skills	<i>Please describe: Compared to what was outlined above, how have typical daily skills and abilities changed? Is the individual still participating in baseline abilities, routine tasks, and household chores? Has job performance or participation in day program activities changed?</i>
Memory	<i>Please describe: What concerns are there about memory skills? Increased forgetfulness, confusion, disorientation, poor concentration? Repeated stories or repeated questions? Forgetting names, mixing up days of the week, etc? What has changed compared to above?</i>
Behavior	<i>Please describe: How have behaviors been lately? Are new behaviors emerging? Has there been a change in the frequency or intensity of typical behavior patterns? Any other new triggers for behaviors noted?</i>
Language	<i>Please describe: Have language abilities changed lately? Is the individual able to let their needs be known per usual? Has vocabulary gotten smaller or verbal output declined overall? Difficulty finding words? Difficulty hearing and answering questions, or difficulty following verbal instructions?</i>
Personality	<i>Please describe: Any recent shifts in personality? Increased irritability, stubbornness, intolerance to change, withdrawal? Any other observed changes compared to baseline?</i>
Mood	<i>Please describe: Have there been observed changes in typical mood? Increased mood swings, tearfulness, sadness, withdrawal? Hearing voices? Seeing or hearing things that are not there?</i>