

DR. SHEDLACK REQUEST for CONSULTATION REFERRAL

(to be submitted by the DDS Area Office nurse)

Date of Initial Request: [Click here to enter a date.](#)

Name of Individual Being Referred:

Gender:

Date of Birth:

Address:

Area Office Nurse:

Email:

Phone Number (& extension):

Service Coordinator:

Email:

Phone Number (& extension):

DDS Area Office Mailing Address:

Phone Number & Fax:

Legal Status of Individual Being Referred:

Name of Guardian (if pertinent):

Phone Number:

Living: Independent / With Family / Shared Living or AFC / Group Home / Staffed Apt / Other

Reason for referral (what changes have been noted in the person's level of functioning and/or what behavioral changes are taking place over what period of time?):

Current Psychiatric, Neurological and Medical Diagnoses:

Level of Intellectual Disability:

Verbal or Non-Verbal

Any recent Psychological, Psychiatric, Medical or Neurologic evaluations or Laboratory results: *

Medications (list or attach a list of all medications, including vitamins, creams/topicals, eye/ear drops, herbal/natural supplements, and any over-the-counter medications the person takes on a regular basis):

Pertinent history of medication trials and outcomes:

History of inpatient psychiatric admissions (please provide discharge summaries):

Please indicate any significant behavioral issues:

Behavior Plan? *

Please indicate any significant recent environmental changes or issues (changes in living situation, day programming, work, social, family, relationships, losses, etc.):

*please attach a copy to referral

****CONFIDENTIAL MEDICAL INFORMATION****