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**Massachusetts Department of Developmental Services**

**Aging Consultation Program**

Referral request and new client intake form

Thank you for your interest in the Aging Consultation Program, a service supported by the MA Department of Developmental Services (DDS) to address questions or concerns of clients who are growing older. Consultations are provided by Julie A. Moran, D.O., a board-certified internist and geriatrician specializing 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.

**Consultation appointments are virtual** in-depth encounters that include the individual and other designated members of the support team. Appointments are held through a secure video platform. An internet connection and a video-capable device is necessary for the individual to be properly assessed. If an individual is under guardianship, it is expected that guardians are notified of this referral. \*\*Please also ensure timely notice of any other necessary accommodations

**Completed forms are to be sent electronically to Lisa Cobb, program coordinator, at** **lisa.cobb@mass.gov**

Thank you! We look forward to working with you.

Client Information Referring DDS Area Office Information

**Area office location:**

**Area office nurse:**

**Service Coordinator:**

**Date of referral:**

 Reason for Referral

[ ]  **Concerns about memory**

[ ]  **Concerns about behavior**

[ ]  **Concerns about function/mobility**

[ ]  **Concerns about mood**

[ ]  **No current concerns, seeking baseline assessment**

[ ]  **Other: please specify**

***What has been done thus far to evaluate these concerns?***

**Name:**

**Date of birth:**

**Street address:**

**Town/City/Zip:**

**Gender identity**:

**Primary contact for booking appointment:**

Name:

Relationship to client:

Email address:

Best phone number:

**Guardian or Health Care proxy (if applicable)**

Name:

Mailing address:

Town/State/Zip:

Email address:

Best phone number:

**Primary Care Provider:**

Name:

Practice location:

 Developmental History and Social History

**Intellectual disability diagnosis**: **Age of diagnosis**:

**Primary residence during childhood**?

[ ] family home [ ] state institution/residential school [ ] other (describe)

**Highest level of education achieved**:

[ ] no formal education [ ] elementary/middle school [ ] high school [ ] vocational training [ ] college

**Current living situation**

[ ] lives with family [ ] community group residence [ ] supported community living *(independent home with supports*)

[ ]  shared living [ ] adult foster care [ ] other (describe):

**Employment/Day program**

[ ] Employed (full or part time) [ ] Community based day services [ ] Day program [ ] Adult day health

[ ] Home based programming [ ] Other (describe):

**Marital status:**

[ ] single [ ] married [ ] divorced/separated [ ] widowed

**Habits: \****please specify current or former use, when applicable*

[ ] tobacco use [ ] alcohol use [ ] drug use

Medical History

***Please list all current and past medical diagnoses, including past surgeries***

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Psychiatric History ***\*please list psychiatric diagnoses and details of any past psychiatric hospitalizations***

**Psychiatric provider’s name:**

**Practice location**:

**Counselor/therapist name**:

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Medications *\*please list any current prescription, over-the-counter, and “as needed” medications. Provide the most current list, with all details included regarding medication name, dose, and frequency. If a medication list is to attached, please ensure that it is the most current list and contains the required details.*

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| **medication name** | **dose (strength)**  | **frequency** |
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Allergies: ***\*\*please list all medication allergies***

Family History ***\*\*this pertains primarily to immediate family members: mother, father, siblings.***

If any immediate family members (mother, father, siblings) are deceased, please list cause of death, if known:

Does anyone in the **immediate** family have a history of dementia, seizures or other neurologic disorder, or other chronic illness? Please describe:

Current health concerns ***\*please indicate any additional current areas of concern***

[ ] Vision change/loss [ ] Falls [ ] Worsening/poor quality sleep

[ ] Hearing change/loss [ ] Unsteady gait, balance [ ] Seizure activity, or question of seizures

[ ] Dental pain, dental concerns [ ] Weight loss [ ] Tremors

[ ] Urinary incontinence/accidents [ ] Poor appetite, food refusal [ ] Worsening pain or discomfort

[ ] Fecal incontinence/accidents [ ] Swallowing dysfunction [ ] Other (describe)

BASELINE Abilities and Characteristics

On this page, please answer the questions describing the individual’s **long standing** **historic abilities, talents and skills throughout lifetime.** This will help describe the individual’s unique **BASELINE** set of skills. In this section responses are focused on describing what was ***typical for an individual throughout adulthood at their very best****.*

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| **Function** | *Please describe the individual’s baseline abilities in daily personal care – dressing, bathing, toileting, grooming, eating, and walking around. How capable/independent was the individual throughout lifetime?*  |
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| **Skills** | *Skills refer to the individual’s abilities above and beyond personal care skills. Describe (for example) academic abilities (reading/writing), employment, capability with household chores, leisure skills, hobbies, interests, etc. throughout lifetime.* |
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| **Memory** | *Memory skills at baseline can include an individual’s ability to follow a schedule, keep track of days/dates/routines, learn and remember names and other information, navigate around familiar areas, recall recent information, etc.*  |
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| **Behavior** | *Please describe any longstanding behavior challenges – including any patterns of aggression, verbal or physical outbursts, self injury, compulsive or repetitive behaviors, etc. Please also describe any behavioral quirks or patterns of preferences – self talk, imaginary friends, etc.*  |
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| **Language** | *Please describe abilities for verbal expression throughout lifetime and abilities to hear and understand speech. If no verbal expressive speech was ever achieved, please describe how communication typically took place and how the individual would express needs and wants.* |
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| **Personality** | *Please describe the individual’s lifelong personality traits.* |
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| **Mood** | *Please describe lifelong mood patterns, highlighting any particular longstanding patterns or observations. Please also include longstanding other mood features throughout lifetime, such as paranoia, hallucinations, delusions, mood cycles, etc.*  |
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CURRENT Abilities and Characteristics

On this page, 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.

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| **Function** | *What changes have been noted lately about the individual’s abilities with daily personal care? Is there a need for assistance with dressing, bathing, toileting, grooming, eating, and walking around? Describe.* |
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| **Skills** | *What changes have been noted in the individual’s daily skills compared to baseline, including any academic abilities (reading/writing), performance of job tasks, capability with household chores, leisure skills, hobbies, interests, etc. Describe.* |
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| **Memory** | *What changes have been noted with memory compared to baseline skills? Describe any patterns of forgetfulness, confusion, disorientation, difficulty learning new information or carrying out tasks per usual, etc.*  |
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| **Behavior** | *Have there been changes in behaviors recently? How does this compare to baseline behavior patterns? Any new patterns emerging?*  |
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| **Language** | *Has there been a change in the individual’s ability to effectively use speech or verbal communication compared to baseline? Is there any change in ability to follow instructions or to understand spoken, written, or other communication?*  |
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| **Personality** | *Have there been new changes in the individual’s personality? Describe.* |
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| **Mood** | *What changes are being noted with mood? Any concerns about worsening mood patterns, withdrawal, sadness, agitation, hostility, etc? Any new or different features of paranoia, delusions, hallucinations?*  |
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