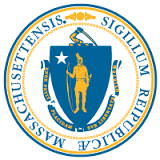
**Massachusetts Department of Developmental Services**



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, Front, Worcester, MA)**, please send your completed form via secure DDS email to Lisa Cobb at:

**lisa.cobb@massmail.state.ma.us** or

**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 **fax to: 978-863-2234**

Thank you! We look forward to working with you.

**Aging and Developmental Disabilities Consultation Program**

**New Patient Referral Request Today’s date:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **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 (\*\**individual typically responsible for booking appointments*) |  | | | |
| Relationship to patient |  | | | |
| Phone number |  | | | |
| Email address |  | | | |
| May we email you with appointment information? |  | Yes |  | No |
| **Primary Care Provider** | | | | |
| PCP Name |  | | | |
| Street Address |  | | | |
| Town/Zip |  | | | |
| Phone Number |  | | | |
| **Other Relevant Specialists** | | | | |
| Psychiatrist's Name  (if applicable) |  | | | |
| Street Address |  | | | |
| Town/Zip |  | | | |
| Neurologist's Name  (if applicable) |  | | | |
| Street Address |  | | | |
| Town/Zip |  | | | |

*Revised 1/2019*

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| **Reason for Consultation** *(indicate reason with an "X")* | | | | | | | | | | | | | |
|  | Change in memory | | | | | | | | | | | | |
|  | Change in behavior | | | | | | | | | | | | |
|  | Change in mood | | | | | | | | | | | | |
|  | Change in function | | | | | | | | | | | | |
| **When did these changes first occur?** | | | | | | | | | | | | | |
| **What has been done thus far to evaluate these concerns?** (i.e.; referral to other specialists, medical evaluations, imaging (CT or MRI), etc. Please be as specific as possible) | | | | | | | | | | | | | |
| **Developmental History** | | | | | | | | | | | | | |
| Intellectual/Developmental Disability Diagnosis | | |  | | | | | | | | | | |
| Age of diagnosis | | |  | | | | | | | | | | |
| Prior genetic testing? Details? | | |  | | | | | | | | | | |
| Residence during childhood and young adulthood (mark with an "X") | | |  | | Raised in the family home | | | | | | | | |
|  | | State institution/residential school | | | | | | | | |
|  | | Other (describe) | | | | | | | | |
| Education history | | |  | | State institution/residential school | | | | | | | | |
|  | | Public school *(specify highest grade completed)* | | | | | | | | |
|  | | Other (describe) | | | | | | | | |
| **Medical History *(list all current and past medical diagnoses, including past surgeries)*** | | | | | | | | | | | | | |
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| **Psychiatric History *(list all current and past psychiatric diagnoses)*** | | | | | | | | | | | | | |
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| **History of past psychiatric hospitalizations? *(if yes, please specify approximate year, location and reason)*** | | | | | | | | | | | | | |
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| **Current Medications \*including prescription, over-the-counter, and PRN ("as needed") medications and nutritional supplements *(please be as specific as possible)*** | | | | | | | | | | | | | |
| **Name** | | | | | | | **Dose** | | | | | | **Frequency** |
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| **Allergies (please list all below)** | | | | | | | | | | | | | |
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| **Family History** | | | | | | | | | | | | | |
| Intellectual/developmental disability | | | | Mental Illness | | | | | | | | Stroke | |
| Dementia | | | | Heart disease | | | | | | | | Other: (specify) | |
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| **Review of Systems** | | | | | | | | | | | | | |
| **Vision** low vision wears glasses cataracts  Last eye doctor exam: | | | | | | | | | **Weight:** stable recent weight gain recent weight loss | | | | |
| **Hearing** hard of hearing wears hearing aids  Last audiology testing: | | | | | | | | | **Appetite**: stable poor/diminished increased | | | | |
| **Dental**  decay/missing teeth wears dentures no teeth  Last dental visit: | | | | | | | | | **Swallowing**: no issues dysphagia/swallow dysfunction Requires modified diet requires pacing/supervision | | | | |
| **Seizures**  history of seizures concern for possible seizure activity | | | | | | | | | **Sleep:** stable  insomnia fragmented sleep  frequent daytime napping snoring  sleep disorder | | | | |
| **Incontinence:**  none urinary fecal | | | | | | | | | **Pain:**  none reported pain suspected pain reported  Is the patient a reliable reporter of pain? Yes  No | | | | |
| **Walking:**  steady unsteady depth perception difficulties Requires assistive device recent falls | | | | | | | | | **History of head injury?** No  h/o concussion  h/o traumatic injury repeated self-injury involving head | | | | |
| **Other:** | | | | | | | | | | | | | |
| **Social History** | | | | | | | | | | | | | |
| **Living situation** | | supported community living  lives with family  community residence  adult foster care | | | | | | | | shared living  nursing home  other (please specify): | | | |
| **Level of supports at home** | | 24 hour supervision  With awake overnight staff  With asleep overnight staff  Case management | | | | | | | | PCA or home health aide  Program nurse  Visiting nurse  Homemaker  Respite | | | |
| **Employment/Day Program** | | Community-based employment  Vocational/ employment program  Day program | | | | | | | | Day habilitation  Home based programming  None | | | |
| **Marital Status** | | Single Married Divorced/separated Widowed | | | | | | | | | | | |
| **Habits** | | Tobacco use  Former  Current | | | | Alcohol use  Former  Current | | | | | Drug use  Former  Current | | |
| **Any additional comments:** | | | | | | | | | | | | | |
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| **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.* | |
| **Function** | *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?* |
|  |
| **Skills** | *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?* |
|  |
| **Memory** | *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 reliable recall recent past events, such as what they ate for lunch, who they saw yesterday? Any particular memory talents?* |
|  |
| **Behavior** | *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?* |
|  |
| **Language** | *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 - i.e. signs, gestures, etc. Could the individual understand verbal language? Answer questions appropriately or follow a verbal instruction?* |
|  |
| **Personality** | *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, i.e. stubbornness, resistance/intolerance to change in routine, etc.* |
|  |
| **Mood** | *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.* |
|  |
| **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** | *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?* |
|  |
| **Skills** | *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?* |
|  |
| **Memory** | *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?* |
|  |
| **Behavior** | *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?* |
|  |
| **Language** | *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?* |
|  |
| **Personality** | *Please describe: Any recent shifts in personality? Increased irritability, stubbornness, intolerance to change, withdrawal? Any other observed changes compared to baseline?* |
|  |
| **Mood** | *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?* |
|  |