**Are there other people that should be contacted for the intake process and scheduling? (Guardian/Family member/Provider Staff/OT/PT/SLP)**

* **Yes ☐ No**

|  |  |  |
| --- | --- | --- |
| **DATE OF REFERRAL** | Click or tap to enter a d | Please ensure the subject line in the email states:**Secure: AT Referral** |

**(This should only be the individual’s information)**

|  |  |
| --- | --- |
| **Name** | Click or tap here to enter text. |
| **Date of Birth** | Click or tap here to enter text. |
| **Diagnosis** | Click or tap here to enter text. |
| **Address** | Click or tap here to enter text. |
|  | Click or tap here to enter text. |
| **Email** | Click or tap here to enter text. |
| **Phone** | Click or tap here to enter text. | * Cell
 | * Landline
 |
|  | **Can a message be left?** | * Yes
 | * No
 |

|  |
| --- |
| **Please include the following medical information for the individual so that appropriate recommendations may be submitted to insurance** |
| **Primary Care Physician Name:** Click or tap here to enter text. | **Phone:** Click or tap here to enter text. |
| **Date of last in person visit:** Click or tap here to enter text. |  |
| **Primary Insurance:** Click or tap here to enter text. | **ID Number:** Click or tap here to enter text. |
| **Secondary Insurance:** Click or tap here to enter text. | **ID Number:** Click or tap here to enter text. |

|  |  |  |  |
| --- | --- | --- | --- |
| **Guardian Name** | Click or tap here to enter text. | **Contact** | Click or tap here to enter text. |
| **Family Member** | Click or tap here to enter text. | **Contact** | Click or tap here to enter text. |
| **Additional Providers** | Click or tap here to enter text. | **Contact** | Click or tap here to enter text. |
| **Additional Caregivers** | Click or tap here to enter text. | **Contact** | Click or tap here to enter text. |
| **Agency/Vendor staff** | Click or tap here to enter text. | **Contact** | Click or tap here to enter text. |
| **OT/PT/SLP** | Click or tap here to enter text. | **Contact** | Click or tap here to enter text. |
| **OT/PT/SLP** | Click or tap here to enter text. | **Contact** | Click or tap here to enter text. |

|  |
| --- |
| **Please indicate those domain areas (in order of priority) that the person is interested/would benefit in having greater independence. (Select via the drop down menu)** |
| **Domain Area Priority 1:** Choose an item. |
| **Domain Area Priority 2:** Choose an item. |
| **Domain Area Priority 3:** Choose an item. |
| **Domain Area Priority 4:** Choose an item. |
| **Domain Area Priority 5:** Choose an item. |
| **Reason for Referral: Brief description can include multiple areas:** |  |
|  |

**REMOTE SUPPORT INTEREST**

|  |
| --- |
| **Is this individual also interested in Remote Supports and Monitoring** |
| **Who is the preferred provider of Remote Supports and Monitoring** |  |
| **Contact Information of Remote Supports and Monitoring Provider** |

**REFERRING DDS SERVICE COORDINATOR:**

|  |  |
| --- | --- |
| **Name** | Click or tap here to enter text. |
| **Title** | Click or tap here to enter text. |
| **DDS Area Office** | Click or tap here to enter text. |
| **Email** | Click or tap here to enter text. |
| **Phone** |  | * Cell
 | * Landline
 |

**DDS APPROVAL:**

Area Director or designee review and approval is required prior to sending to AT Provider that the individual selected.

|  |  |
| --- | --- |
|  **FMIS Authorization Required**  | Number |

|  |  |
| --- | --- |
| **PROVIDER REFERRED TO:** | **Tap to select** |
| **DATE REFERRAL SENT:** | Click or tap to enter a date. |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Is an AT Screening Assessment Attached?** | * YES
 | * NO
 |  | **Is her/his ISP Attached?** | * YES
 | * NO
 |

Enter any content that you want to repeat, including other content controls. You can also insert this control around table rows in order to repeat parts of a table.