**Date of Initial Request:** Click here to enter a date.

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| --- | --- | --- | --- |
| **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.):** | | | |