**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.):**       |