Developmental Services - Referral Form

Identifying Information

Referral Date: _____ Person's Name: _____

Age: Gender: Male☐ Female ☐ Ambulatory ☐ Non-Ambulatory ☐

Diagnosis:

Medical Conditions:

Current Location: Guardian/AR: Yes ☐ No ☐

Wants and Needs:

Dislikes and Fears:

Does individual have a waiver? ☐ Yes ☐ No

Please indicate type of funding: ☐ DD Waiver ☐ Self-pay

Type of service seeking. Check all that apply

☐ Family Care (Sponsored Residential) ☐ In-Home ☐ Group Home ☐ Group Day
☐ Supervised Residential ☐ Center Based Respite (Arlington County Only) ☐ Skilled Nursing
☐ Community Coaching ☐ Community Engagement

Does individual have a location preference? ☐ Yes ☐ No
Please list preferred area of state:
How soon is placement needed?
Reason for seeking services?

Does individual have a current SIS? ☐ Yes ☐ No Date completed:

Referring Agent Information

Name of referring person:

Role of referring person: ☐ Parent ☐ Guardian/AR ☐ Support Coordinator/Case Manager
☐ Internal ☐ Other: _____
Phone: ( ) Email:

Current meds: please attach separate sheet separate sheet if printing form off.
If you are completing on-line please type information in here.

Clinical Screening

☐Danger to Self/Others ☐Physical Aggression ☐Sexually Inappropriate ☐ Elopement ☐ Other:

Adaptive Functioning Skills Needs Assessment:

☐ Self-Care	☐ Dressing	☐ Home living	☐ Health and Safety
☐ Safe food handling	☐ Employment (work)	☐ Money management	☐ Cleaning
☐ Social skills	☐ Personal responsibility	☐ Communication skills	☐ Transitioning
☐ Toileting	☐ Community use	☐ Leisure activities	☐ Self-Direction
☐ Making choices	☐ Learning and following a schedule	☐ Completing necessary or required tasks	☐ Behavioral skills

If you have any additional information, please attach a separate sheet.
If you are completing on-line, please type in here.

Additional Needs

Does the person use adaptive equipment? Please list:

Does the person have specific dietary needs? Please describe:

How does the person communicate? Check all that apply
☐ Vocal ☐ Gestures ☐ Picture exchange ☐ Sign language ☐ AAC device ☐ Other:

What is the preferred method of communication?

Does the person use any of these services?

☐ Physical Therapy	☐ Occupational Therapy	☐ Speech/Language	☐ Neurology
☐ Psychiatry	☐ Behavior Therapy	☐ Counseling	☐ Home Health
☐ Private Duty Nursing	☐ Skilled Nursing	☐ Hospice	

Previous Living Situations

Has the person received any of these services?

Check all that apply: ☐ Group Home ☐ Sponsored Residential Home ☐ Supported Living

☐ Independent Apartment/Home ☐ Other: _____