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Behavioral Consultation Referral

*****please be sure to complete ALL areas*****

Referral Date: _____

Funding Source:
- ☐ DD Waiver, Community Living
- ☐ DD Waiver, Family/Ind.Supports
- ☐ CSA
- ☐ Schools
- ☐ IFSP
- ☐ Private Pay
- ☐ Other: _____

If Waiver Referral **Medicaid #:** _____ **PCP Start Date:** _____ **PCP End Date:** _____

Individual's Name: _____ **DOB:** _____

Address: _____ **Phone#:** _____

Guardianship: Self? ☐ Yes ☐ No **If No, please provide the following information:**

Guardian's Name: _____
Address: _____
Phone / Fax: _____

Type of residential supports: ☐ Group home ☐ Supported Living Services ☐ Foster home ☐ Independent Living ☐ Family home ☐ Respite ☐ None ☐ Other : _____

Individual is involved with REACH ☐ Yes ☐ No
If yes, describe the nature of involvement: _____

Requesting services at the following locations and with the following support providers:

Home
Contact Person: _____ **Phone:** _____
* **Relationship to individual:** _____
Address: _____
Time / days services will be most needed: _____
* **Provider name (if applicable):** _____

Other
Contact Person: _____ **Phone:** _____
* **Relationship to individual:** _____
Address: _____
Time / days services will be most needed: _____
* **Provider name (if applicable):** _____

Other
Contact Person: _____ **Phone:** _____
* **Relationship to individual:** _____
Address: _____
Time / days services will be most needed: _____
* **Provider name (if applicable):** _____

Reason for referral (*mark all that apply*)

☐ **Physical Aggression** (mark all that apply)

☐ Hitting ☐ Kicking ☐ Spitting ☐ Pushing ☐ Shoving ☐ Pinching ☐ Scratching

☐ Head-butting ☐ Biting ☐ Other:_____

☐ **Verbal Aggression** (mark all that apply)

☐ Use of swear words / foul language toward another individual ☐ Threats

☐ Derogatory statements/name calling ☐ Yelling at someone ☐ Teasing ☐ Bullying

☐ Aggressive sexual comments ☐ Other:_____

☐ **Verbal Disrespect** (mark all that apply)

☐ Interrupting ☐ Name calling ☐ Talking back / arguing

☐ Inappropriate sexual comments ☐ Other:_____

☐ **Emotional Outbursts** (mark all that apply)

☐ Screaming ☐ Yelling ☐ Crying ☐ Other:_____

☐ **Non-compliance** (mark all that apply)

☐ Saying "no" to non-negotiable requests ☐ Arguing with instructions

☐ Looking away / ignoring directions ☐ Continuing with previous activity

☐ Other: _____

☐ **Self-injurious Behaviors** (mark all that apply)

☐ Hitting ☐ Biting ☐ Pinching self ☐ Head-banging ☐ Poking eyes ☐ Skin picking

☐ Other:_____

☐ **Property Destruction**

☐ **Elopement**

☐ **Suicidal Ideations / Suicide Attempt(s)**

☐ **Hallucinations** (mark all that apply)

☐ Auditory ☐ Visual

☐ **Substance Abuse**

☐ **Stealing**

☐ **Frequent Psychiatric Hospitalizations** How often? _____ Date of last hospitalization: _____

☐ **Placement At Risk** (please explain:) _____

Summary of Reason for Referral: _____

_____

Diagnoses (must also include level of ID) ☐ Mild ID ☐ Moderate ID ☐ Severe ID ☐ Profound ID

☐ Unspecified ID ☐ Autism ☐ Cerebral Palsy ☐ Other _____

☐ Mental Health - list primary psychiatric diagnosis: _____

What do you/individual/family/providers hope to accomplish through Behavioral Consultation?

_____

_____

_____

Service Coordinator Name	Date	Direct Phone	Fax	Email address