A referral source’s initial point of contact should be made by calling the Development Disabilities Unit at 508-838-2273 and asking for the Nurse Manager.

Other points of contact may be through the Arbour Health System ACCES/Intake Department at 800-22-ACCES; intake coordinators will direct the referrer to call the Development Disabilities Unit Manager or other applicable staff regarding the admission.

All referrers should complete a Patient Referral Form related to the admission. The completed Form must be faxed to the Developmental Disabilities team at 508-838-2228 – this will be reviewed within 24 hours of receipt (includes business days only).

Referral source will be notified if the patient will be admitted or placed on a waiting list. Projected bed availability will be identified at that time.

Once the patient is accepted and a date is identified for admission, the Unit Manager informs ACCES/Intake that the patient has been accepted for admission and patient eligibility/insurance will be verified. The referral source is also notified to contact ACCES/Intake to review insurance information. Verification of insurance may include the request for a 1:1, and the Specializing Form, which is attached, may also need to be completed by the referral source.

The referral sources are notified no less than once a week of current bed availability.

The waiting list is managed on the unit by the Nurse Manager.
I, _____________________________________, officially representing Area_________________________ of the Department of Mental Retardation, hereby authorize the reimbursement of 1:1 (specialing) at the rate of $20.00 per hour for the patient listed below for as long as clinically necessary, as determined by the clinical team of the Developmental Disabilities Unit at Arbour-Fuller Hospital. The determination of need for the 1:1 will be evaluated every 24 hours, and any change in status will be communicated to the DMR representative immediately.

___________________________________  _____________________________________
DMR Representative                        Date

___________________________________
Patient Name
ARBOUR-FULLER HOSPITAL
DEVELOPMENT DISABILITIES UNIT
Patient Referral Form

Patient Name: ___________________________ Age: _______ DOB: _______
DMR Service Coordinator/DMR Area _______ Phone: _______________ EXT: _______
Guardian Name: ___________________________ Phone: ______ Region 5? Yes No
Insurance: ____________________________________________________________
MR Level: Borderline___ Mild ___ Moderate ___ Severe ___ Profound ___
Primary Mode of Communication: Verbal___ Sign ___ Pictures ___ Gestures (point, etc). ___
Reason for referral/describe behaviors:
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________
Use back side if needed
Current Sleep Pattern (note recent changes): ___________________________________
Eating Problems (include special diet, change in appetite): ___________________________
_________________________________________________________________
Physical Disabilities: _______________________________________________________
Can have roommate? Yes___ No____ 1:1 in Community? Yes___ No___ 1:1 Needed? Yes___ No___
Seizures? Yes ___ No _____ Diabetes? Yes ___ No ___
Thyroid Disorder? Yes ___ No _____ Heart Condition? Yes ___ No ____ Other Medical Issues? _______________________
Current Medications (include dosages and recent changes): _______________________
_________________________________________________________________
Allergies: ________________________________
Psychiatrist/Therapist: ___________________ Phone: _________________________
PCP: ________________________________ Phone: _________________________
Neurologist: __________________________ Phone: _________________________
Disposition Plan* Return Home ___ Respite ___ Unknown Other: _______________
Contact Person: ______________________ Phone: _______________________

PLEASE FAX THIS FORM BACK TO 508-838-2228