



**ARBOUR-FULLER
HOSPITAL**
A Division Of Arbour Health System
INTELLECTUAL DISABILITIES UNIT
Patient Referral Form

Patient Name: _____

Age: _____

DOB: _____

DDS Service Coordinator/DDS Area Phone and ext.: _____

Guardian Name: _____

Phone: _____

DDS Region V? Yes ___ No ___ Other DDS Region: (please identify) _____

Insurance: _____

MR Level: Borderline ___ Mild ___ Moderate ___ Severe ___ Profound ___

Primary Mode of Communication: Verbal ___ Sign ___ Pictures ___ Gestures (point, etc). ___

Reason for referral/describe behaviors:

Current Sleep Pattern (note recent changes):

Eating Problems (include special diet, change in appetite):

Physical Disabilities:

Can have roommate? Yes ___ No ___ If no, please explain: _____

1:1 in Community? Yes ___ No ___ If yes, please explain: _____

1:1 Needed? Yes ___ No ___ If yes, please explain: _____

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/Person completing form: _____

Phone: _____

PLEASE FAX THIS FORM TO 508-838-2228