FULLER HOSPITAL
LEADING THE WAY IN BEHAVIORAL HEALTH

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:

____

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____

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____

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?

____

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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