

## DDA Crisis Diversion Bed Referral and Intake Information

CLIENT'S FULL NAME		DATE OF BIRTH	SOCIAL SECURITY NUMBER
NAME OF PERSON MAKING REFERRAL	TELEPHONE NUMBER	<input type="checkbox"/> DMHP <input type="checkbox"/> Other <input type="checkbox"/> DDA	
DDA CASE RESOURCE MANAGER		DDA / MH CRM TELEPHONE NUMBER	
RESIDENTIAL AGENCY PROVIDER		PROVIDER TELEPHONE NUMBER	
FAMILY/LEGAL REPRESENTATIVE		<input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> Medicare Part D Provider:	
Current Housing Situation			
Communication Style (nonverbal/verbal, primary language, preferred modes):			
Diagnosis:			
Briefly describe why this person is being referred. List current symptoms/behaviors of concern (define and state frequency and severity of each symptom/behavior).			
History of Violent/Dangerous Behaviors and No Contact Orders:			
History of Fire-Setting:			
History of Sexual Abuse/Assault:			
History of Substance Abuse:			
History of Vandalism/Destructive Behavior:			
Legal History (DOC, jail, mental health commitments, chemical dependency commitments):			

Is person on a Court Order or LRA? <input type="checkbox"/> Yes <input type="checkbox"/> No	NAME OF CORRECTIONS/PAROLE OFFICER	TELEPHONE NUMBER	
Previous Mental Health Involvement:			
MEDICATION	DOSAGE	AMOUNT	Describe all known allergies:
Describe all Known Physical and Medical Problems:			
Describe all Known Treatments:			
CURRENT GENERAL PHYSICIAN			TELEPHONE NUMBER
CURRENT MH PRESCRIBER			TELEPHONE NUMBER
Is the person ambulatory? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Does the person use a prosthetic device? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, describe:			
Is the person willing to take medications as prescribed? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Date of last medication review:			
Known Appointments Scheduled (who/where/when):			
Treatment Plan/Goals for the Person.			
Other important information:			
Discharge Plans:			

Hobbies/Interests:

Favorite Foods:

Favorite Places:

Dislikes:

Information Checklist:

- Fax/Send Signed Physician's Orders
- Cross System Crisis Plan
- Functional Assessment
- Positive Behavior Support Plan
- Individual Support Plan (ISP)
- Psychiatric/Psychological Evaluation
- Treatment Plan
- Guardianship Documentation
- Current Medication Record

SIGNATURE OF PERSON COMPLETING FORM

TITLE

DATE

**TO BE FILLED OUT BY CRISIS DIVERSION BED PROVIDER**

Person accepted?  Yes  No

Who is transporting the person?

PROVIDER SIGNATURE

TITLE

DATE