NewWave Behavioral Consultation Referral Form

NewWave Behavioral Consultation

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Referral Date: _____

Funding Source: □ DD Waiver- Please note which Waiver, *Community Living* or *Family and Individual Supports* Waiver: _____

□ CSA □ Schools □ IFSP □ Private Pay □ Other

If Waiver referral, Medicaid#: _____ DOB: _____

If Waiver referral, PCP Start/End Dates: _____

Individual's name: _____

Address: _____ Phone #: _____

Guardianship: Self? □ Yes □ No **If no, please provide the following information:**
Guardian 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 type 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: _____

Other: Contact Person: _____ Phone#: _____
*Relationship to individual: _____
Address: _____
Time/Days services will be most needed: _____
*Provider Name: _____

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Reason for referral (*please check and circle all that apply*):

□ Physical Aggression (**circle all that apply**: hitting, kicking, spitting, pushing, shoving, pinching, scratching, head butting, biting, other: _____)
□ Verbal Aggression (**circle 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 (**circle all that apply**: Interrupting, name calling, talking back/arguing, inappropriate sexual comments, other: _____)
□ Emotional Outbursts (**circle all that apply**: screaming, yelling, crying, other: _____)
□ Non-compliance (**circle all that apply**: Saying "no" to non-negotiable requests, arguing with instructions, looking away/ignoring directions, continuing with previous activity, other: _____)
□ Self-Injurious Behaviors (circle all that apply: Hitting, biting, pinching self, head-banging, poking eyes, skin picking, other: _____)
□ Properly Destruction
□ Elopement
□ Suicidal Ideations/Suicide Attempts
□ Hallucinations (circle all that apply: auditory or 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 □ Downs Syndrome □ Mental Health- list primary psychiatric diagnoses_____

What do you/individual/family/providers hope for Behavior Consultation Services to accomplish?

_____
_____
_____

_____ _____
Service Coordinator Name/Signature ***Date***

_____ _____ _____
Direct Phone # ***Fax #*** ***Em***