Referral Form

REFERRER DETAILS:	
Name of Referral Source & Agency:	Referral Date:
	Phone:
Relationship to the Client	Fax/ Email:

CLIENT INFORMATION:		
First Name:	Last Name:	Middle Initial:
Preferred Name:	☐ Female ☐ Male ☐ Other/Unknown	DOB: (mm/dd/yy)
Address:		Primary Phone:
Email Address:		Alternate Phone:
Primary Language:		Translator Required: ☐ Yes ☐ No

SUPPORT NETWORK:			
Primary Contact:	Relationship: (role, agency)	Phone:	Alternate: (email/phone)
Next of Kin: ☐ Same as above	Relationship:	Phone:	Alternate: (email/phone)
Primary Health Care Provider:		Phone:	Fax:
Specialist Involvement: (i.e. psychiatrist, neurology, metabolic, etc.)		Phone:	Fax:
Other Service Providers: (i.e. day program, behavioral, counselor, agency, PGT)		Phone:	Fax:

LEGAL DECISION MAKING: *(Please attach a copy of the legal documentation, if applicable)			
Is the client aware of this referral? ☐ Yes ☐ No		Is the client's family aware of this referral? ☐ Yes ☐ No	
Substitute Decision Maker Representative or Committee of Person who makes health care decisions on behalf of the client? ☐ Yes ☐ Unsure ☐ No (client is their own decision maker)			
If Yes, Name of Decision Maker:	Relationship:	Phone:	Alternate Contact:

REFERRAL DETAILS: *(Please attach ISP, any available history and/or assessments)
Presenting Problems: (Please describe the current symptoms of mental illness. Include substance use, suicide risk, and risk of aggression)
Services Requested/ Desired Outcome:

Current Concerns (within past 3 months):

	Yes	No	Unsure		Yes	No	Unsure
Disturbed Sleep	☐	☐	☐	Behavior Change	☐	☐	☐
Appetite Changes	☐	☐	☐	Verbal Aggression	☐	☐	☐
Mood Changes	☐	☐	☐	Physical Aggression	☐	☐	☐
Suicidal Thoughts	☐	☐	☐	Self-Harm	☐	☐	☐
Psychosis	☐	☐	☐	Frequent Hospitalizations	☐	☐	☐
Change in Energy	☐	☐	☐	Change in Concentration	☐	☐	☐
Safety Issues	☐	☐	☐	Medication Side Effect	☐	☐	☐
Alcohol/Drug Use	☐	☐	☐	Other:			

Send Completed Referrals to:	
Email	referral@defyingao.com
Fax	(717) 500-2927

Who Can Refer?

Only Supports Coordinators can refer adults (aged 18+).

Instructions for Completing this Referral:
Please complete pages 1 and 2 of the referral form in full, and print clearly. An incomplete referral may result in delays to the client being seen.

Please include a copy of the most current ISP with referral.

To ensure timely processing, please FAX the completed referral form (pages 1 and 2) and all supporting information to the correct contact (listed on page 2 of the referral form).

Please note: DOA is a specialized team, and our screening process is thorough. This may take time, as we collect the necessary information related to the referral.

The client and/or primary contact person will be contacted directly to discuss eligibility and service needs. Client will be notified directly of the outcome of this referral.

Eligibility Criteria:

☐ Must have a diagnosis of developmental disability with an IQ under 70. Previous Psychological or Psycho-educational Assessment, which indicates the clients the clients FSIQ, may be required *(see not below)

☐ Client is 18 years of age or older

☐ Client is requiring a consultation and/or assessment.

The following referrals will not be accepted:

☐ Client is not experiencing an exacerbation of mental health symptoms and/or behavior concerns.

☐ Clients seeking counseling as their only resource.

☐ Client seeking residential, vocational, or life skill supports

☐ Clients seeking a Psychological or Psycho-Educational Assessment.