Washington State Department of Social & Health Services
Transforming lives

DEVELOPMENTAL DISABILITIES ADMINISTRATION (DDA)

# DDA Crisis Diversion Bed Referral and Intake Information

| | | | |
|---|---|---|---|
| CLIENT'S FULL NAME | | DATE OF BIRTH | ADSA NUMBER |
| NAME OF PERSON MAKING REFERRAL | TELEPHONE NUMBER | ☐ DMHP ☐ OTHER: ☐ DDA | |
| DDA CASE RESOURCE MANAGER | | DDA / MH CRM TELEPHONE NUMBER | |
| RESIDENTIAL AGENCY PROVIDER | | PROVIDER TELEPHONE NUMBER | |
| FAMILY / LEGAL REPRESENTATIVE | | REPRESENTATIVE TELEPHONE NUMBER | |
| ☐ MEDICAID ☐ MEDICARE ☐ MEDICARE PART D PROVIDER: | | ☐ OTHER INSURANCE: | PROVIDERONE ID |

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:

Is this individual a Community Protection Participant? ☐ Yes ☐ No

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? ☐ Yes ☐ 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? ☐ Yes ☐ No

Does the person use a prosthetic device? ☐ Yes ☐ No
If yes, describe:

Is the person willing to take medications as prescribed? ☐ Yes ☐ No
Date of last medication review:

Known Appointments Scheduled (who / where / when):

Treatment Plan / Goals for the Person:

Client Financial Resource Information:

Other important information:

Discharge Plans:

Hobbies / Interests:

Favorite Foods:

Favorite Places:

Dislikes:

Information Checklist (documents to be included as appropriate):

- ☐ Signed Physician's Orders
- ☐ Cross System Crisis Plan
- ☐ Functional Assessment
- ☐ Positive Behavior Support Plan
- ☐ Individual Instruction and Support Plan (IISP)
- ☐ CARE Assessment Details
- ☐ Psychiatric / Psychological Evaluation
- ☐ Community Protection Treatment Plan and Current Risk Assessment
- ☐ Guardianship Documentation
- ☐ Current Medication Record
- ☐ Other (specify):

| 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 |
|---|---|---|
| | | |