ARBOUR-FULLER
HOSPITAL
A Division Of Arbour Health System

REFERRAL PROCESS FOR THE ADULT DEVELOPMENTAL DISABILITIES UNIT

- A referral source's initial point of contact should be made by calling the Development Disabilities Unit at 508-838-2273 and asking for the Nurse Manager.

- Other points of contact may be through the Arbour Health System ACCES/Intake Department at 800-22-ACCES; intake coordinators will direct the referrer to call the Development Disabilities Unit Manager or other applicable staff regarding the admission.

- All referrers should complete a Patient Referral Form related to the admission. The completed Form must be faxed to the Developmental Disabilities team at 508-838-2228 – this will be reviewed within 24 hours of receipt (includes business days only).

- Referral source will be notified if the patient will be admitted or placed on a waiting list.

- Projected bed availability will be identified at that time.

- Once the patient is accepted and a date is identified for admission, the Unit Manager informs ACCES/Intake that the patient has been accepted for admission and patient eligibility/insurance will be verified. The referral source is also notified to contact ACCES/Intake to review insurance information. Verification of insurance may include the request for a 1:1, and the Specialing Form, which is attached, may also need to be completed by the referral source.

- The referral sources are notified no less than once a week of current bed availability.

- The waiting list is managed on the unit by the Nurse Manager.

Arbour-Fuller Hospital Specialing Form Developmental Disabilities Unit

I, _____, officially representing Area _____ of the Department of Mental Retardation, hereby authorize the reimbursement of 1:1 (specialing) at the rate of $20.00 per hour for the patient listed below for as long as clinically necessary, as determined by the clinical team of the Developmental Disabilities Unit at Arbour-Fuller Hospital. The determination of need for the 1:1 will be evaluated every 24 hours, and any change in status will be communicated to the DMR representative immediately.

_____ _____

DMR Representative Date

_____

Patient Name

ARBOUR-FULLER HOSPITAL DEVELOPMENT DISABILITIES UNIT
Patient Referral Form

Patient Name:
Age:
DOB:
DMR Service Coordinator/DMR Area Phone and ext.:
Guardian Name:
Phone:
Region 5? Yes___ No ___
Insurance:
MR Level: Borderline___ Mild ___ Moderate ___ Severe ___ Profound ___
Primary Mode of Communication: Verbal___ Sign ___ Pictures ___ Gestures (point, etc). ___
Reason for referral/describe behaviors:

_____
_____
_____
_____
_____

Current Sleep Pattern (note recent changes):

_____

Eating Problems (include special diet, change in appetite):

_____

Physical Disabilities:

_____

Can have roommate? Yes___ No ___
1:1 in Community? Yes___ No ___
1:1 Needed? Yes___ No___
Seizures? Yes ___ No ____
Diabetes? Yes ___ No ___
Thyroid Disorder? Yes ___ No ___
Heart Condition? Yes ___ No ___
Other Medical Issues?

_____

Current Medications (include dosages and recent changes):

_____

Allergies:

_____

Psychiatrist/Therapist:
Phone:
PCP:
Phone:
Neurologist:
Phone:
Disposition Plan* Return Home ___ Respite ___ Unknown ___ Other: _____
Contact Person:
Phone:

PLEASE FAX THIS FORM BACK TO 508-838-2228