Referral Form

DD WAIVER SERVICES

FOCUS PERSON

Name:		
Medicaid ID:	Date of Birth:	Sex:__M ___F
Address:		
PHONE:	EMAIL:	
DIAGNOSIS:		
DECISION MAKING:		

	IS THEIR OWN DECISION MAKER		USES A LEGAL SUBSTITUTE DECISION MAKER

DECISION MAKER

Name:
Relationship to Focus Person:
Phone Number:
Email:
Address:
Other Notes:

Please Email Forms to: welcome@trainingheartsva.com
Phone number: 804) 210-5464

Training Hearts
NPI# 1588484588

SERVICE COORDINATOR
Name:
Phone Number:
Email:
Service board/ Location:
Group Home:
Contact Name:
Phone Number:
Email:

Day Support:	
Contact Name:	
Phone Number:	
Email:	
BEHAVIOR CONSULTATION NEEDS (Check all that apply)	
	Sensory Diets
	Physical Aggression
	Property Destruction
	Self-Injurious Behavior
	Inappropriate Verbal aggression
	Undesired behaviors
	Elopement / Wandering
	Obsessive Compulsive Behaviors
	Self-criticism
	Resistance to working with others
	Non-choice activity behavior

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	Inappropriate or Unsafe Sexual Behaviors
	self modulation
	Manipulation
	Lack of discretion.
	Pica (eating non-food items)
	Other:
OCCUPATIONAL THERAPY CONSULTATION NEEDS (Check all that apply)	
	The goal of occupational therapy is to maximize a client's independence in all areas of life. These areas can include self care, home and community management, sleep, education, work, play, leisure, and social participation. Examples: This may include obtaining equipment to increase mobility and access to their home and community. We may modify a task such as simple meal prep or laundry to increase the client's understanding. A home exercise program could be established to improve the client's balance and strength needed to get in and out of the shower or navigate their environment. Maybe the client needs a sensory diet to increase their emotional and sensory regulation at home, work, or day support.
	Activities of Daily Living (bathing, dressing, toileting, self feeding)
	Instrumental Activities of Daily Living (simple meal prep, laundry, money management)
	Establishing Habits & Routines
	Bowel & Bladder Management
	Leisure
	Sleep Hygiene
	Fine Motor Skills (tying shoes, handwriting, opening containers)
	Home Exercise Program (strength, balance, coordination, wellness)
	Transfers (in/out of the bed or shower, on/off of the toilet, standing from soft/ low surfaces)
	Durable Medical Equipment / Adaptive Equipment (wheelchair, tub bench, sock aid, etc.)
	Home Safety Assessment
	Fall Risk Assessment
	Wound Risk Assessment / Prevention

	Sensory / Emotional Regulation
	Difficulty Transitioning Between Tasks or Environments
	Other:
PHYSICAL THERAPY CONSULTATION NEEDS (Check all that apply)	
	Pain Management
	Post-Surgical Rehabilitation
	Recovery from Injury
	Neurological Conditions
	Mobility and Balance Issues
	Pediatric Conditions
	Chronic Conditions
	Post-Amputation Rehabilitation
	Preventative Care and Wellness
	Lymphedema Management
	Orthopedic and Musculoskeletal Issues
	Cardiopulmonary Rehabilitation
	Women's and Pelvic Health
	Workplace Ergonomics and Rehabilitation
	Sports Performance and Injury Prevention
Other:	
Is the individual receiving any other services? Yes_____ no_____	
Services:	
PLEASE INCLUDE WHEN SENDING REFERRAL: **Referral Form: Annual Risk Assessment (SIS): VIDES: Current ISP: VA Informed Choice: Guardianship Documents- If applicable**	

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