Medical Intake Packet for Developmental Disabilities Center

Dear Patient/Parent/Guardian:

Thank you for your interest in the Developmental Disabilities Center. Enclosed you will find our medical/behavioral health intake packet. Below is a checklist to help ensure we receive all pertinent information. It is important for patients who have a court appointed guardian that their signature is on all necessary forms and the DDC is provided with a copy of the guardianship papers.

____ Completed intake form. Fill out both sides

____ Authorization for Release of Information-signed by court appointed guardian-present this form to the physician who has been treating the patient to obtain medical records.

____ Consent for treatment – please refer to the enclosed document, "INSTRUCTIONS FOR COMPLETION OF THE CONSENT FOR TREAT FORM"

____ Copies of all current insurance cards including prescription card (front and back)

____ Copies of guardianship paperwork

____ Social history, psychological evaluation & IHP – obtain from DDD case manager

____ Copy of psychiatric treatment notes

____ Copy of neurological treatment notes

When you have gathered all of the required documents (PLEASE SEND ALL DOCUMENTS TOGETHER)

Please mail (CANNOT ACCEPT FAX) to our office or you may drop of the completed packet to our office. After review of the completed packet by a clinician, we will call the contact person listed to schedule an appointment. RETURN INTAKE PACKET WITH THIS CHECKLIST ATTACHED.

Please call our office if you require assistance.
Thank you.

Developmental Disabilities Center
11 Saddle Road
Cedar Knolls, NJ 07927

P 973-971-4095 F 973-290-7172

Atlantic Health System
Atlantic Medical Group

Medical Intake Packet for Developmental Disabilities Center

Please read the attached consent to treatment guidelines and instructions prior to completion of this form.

Please do not duplicate this form. Contact DDC if you need additional forms.

Today's Date _____ Patient's name:_____

Date of Birth: _____ Male/Female (circle)

Preferred name & language :_____

(must be 21 years of age or older)
Patient's Address:
_____
(Street address, city, state, zip-code)

Type of residence: (circle) family sponsor group home supervised apartment other_____

Contact for appointments: Name_____
Telephone:_____
Fax: _____

Residential agency, if any:
_____

DDD Support Coordinator: _____

Telephone: _____

(check one) _____Contact information for guardian

OR

Contact information for family member:
Name:_____

Address:_____

Telephone: _____

Other: (additional phone or fax) _____

Developmental Disabilities Center
11 Saddle Road
Cedar Knolls, NJ 07927

P 973-971-4095 F 973-290-7172

Atlantic Health System
Atlantic Medical Group

Medical Intake Packet for Developmental Disabilities Center

Why is the Patient coming to DDC? Check all that apply

Primary Medical Care _____
Psychiatry (diagnosis & medication) _____

Current
Concerns:_____
_____
_____
_____
_____
_____

Check all that apply:

Intellectual Disability: Mild___ Moderate_____ Severe____ Profound_____

Autistic Spectrum Disorder____ Down Syndrome_____ Fragile X _____

Fetal Alcohol Syndrome____ Williams Syndrome_____ head injury _____

Other known cause of intellectual Disability_____

Seizure Disorder_____ Cerebral Palsy_____

Psychiatric
diagnosis:_____

Medical diagnosis:
_____

Allergies:
_____

Current Medications: complete the following or attach current MAR:

Medication and dose Directions Reason for taking
_____
_____
_____
_____
_____
_____

Developmental Disabilities Center
11 Saddle Road
Cedar Knolls, NJ 07927

P 973-971-4095 F 973-290-7172

Atlantic Health System
Atlantic Medical Group

_____
_____
_____
_____
_____

Specialists the patient sees: complete the following or attach current list:

Name Specialty Contact Information

_____
_____
_____
_____
_____
_____
_____

Insurance Information: Attach copies of ALL current insurance cards (both sides of cards)
Medicaid ID No._____

Name of Medicaid HMO _____

Medicare No. _____

Other insurance name_____

Prescription/Drug/medical equipment insurance name & ID no.
_____

Name of person completing this form:

_____

How may we contact you if additional information is needed?
_____

Optional: Who suggested using the DDC services for this patient? Source of this referral:

Residential Staff_____ Family _____ Physician _____ ER _____ DDD ____BGS ___
Other _____

Developmental Disabilities Center
11 Saddle Road
Cedar Knolls, NJ 07927

P 973-971-4095 F 973-290-7172

Atlantic Health System
Atlantic Medical Group

Medical Intake Packet for Developmental Disabilities Center

Instructions for Completion of Consent for Treatment Form

The Atlantic Health System requires that the CONSENT FOR TREATMENT form to be renewed yearly. This form must be on file prior to all non-emergent visits. Please read the following directions and sign the consent accordingly. The consent must be signed, dated, timed, and then witnessed, dated, and timed to be complete.

The patient must sign, date and time the consent for treatment. Witness to signature must sign, date, and time form also.

If the patient has a legal guardian or guardian through the NJ Bureau of Guardianship, please have the assigned guardian sign, date, and time the consent form. Witness to the signature must sign, date, and time form also. If not previously provided, please send a copy of guardianship papers required to complete the medical record.

If there is no legal guardian, but there is an involved family member helping make medical decisions, have the family member sign the second line. Print their name and relationship and attach their contact information if the patient doesn't live with them.

IMPORTANT:

If you are the patient's legal guardian, and the relationship does not include financial liability, then be advised that your signature on this consent does NOT make you financially responsible for the patient's DDC medical care costs. The "FINACNCIAL ARRANGEMENTS" section means that the patient is financially responsible for any applicable deductibles, coinsurances and/or non-covered services not paid for by their insurance payer. *Please do not cross out or otherwise change the consent form.*

<u>Please enter the patient name and date of birth in the upper right-hand corner of the consent for treatment form.</u>

Return the white copy to the Developmental Disabilities Center at the address below and retain the blue copy for the patient's record. PLEASE DO NOT RETURN VIA FAX.

If you have any questions, please contact the office at the telephone number shown below.

Developmental Disabilities Center
11 Saddle Road
Cedar Knolls, NJ 07927

P 973-971-4095 F 973-290-7172