

# 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
- New Jersey Individualized Service Plan (NJISP) Behavior Support Plan
- List of medications currently taking
- 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.



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*Please read the attached consent to treatment guidelines prior to completing 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 legal guardian**

OR

Relationship of person completing the form on behalf of the patient

\_\_\_\_\_

Contact information for family member:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

Other: (additional phone or fax) \_\_\_\_\_



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

Primary Medical Care \_\_\_\_\_  
Psychiatry (diagnosis & medication) \_\_\_\_\_

Psychology \_\_\_\_\_

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 list:

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

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\_\_\_\_\_

\_\_\_\_\_

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  
\_\_\_\_\_

## 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

Developmental Disabilities Center  
11 Saddle Road  
Cedar Knolls, NJ 07927



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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 "FINANCIAL 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.*

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

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.

