DDD RESOURCE TEAM BCBA CONSULTATION FORM

Please save and email the completed PDF form to *ddd.resourceteam@dhs. nj.gov*

Please direct questions to *ddd.resourceteam@dhs. nj.gov* or call Supervisor Ken Eley at 609-318-3997

NAME: **DATE:** **DDD ID#:**

Residential Provider:

Residential Address:

Contact Person: **Phone:** **Email:**

Day Services Provider:

Address:

Contact Person: **Phone:** **Email:**

Form completed by: **Title:**

Phone: **Email:** **Supervisor:**

Behavior Specialist: **Phone:** **Email:**

Is Crisis Assessment Response & Enhanced Services (CARES) involved? ☐ Yes ☐ No

CARES Clinician: **Phone:** **Email:**

Ambulatory Status: ☐ Ambulatory ☐ Non-Ambulatory ☐ Ambulates with assistance

NJCAT/Tier:

Communication Style: ☐ Vocal Speech ☐ Gestures ☐ None ☐ American Sign Language (ASL)

☐ Picture Exchange Communication System (PECS) ☐ Augmentative Alternative Communication (AAC)

Please complete for the behaviors of highest concern.

Target Behavior: **Frequency:**

Severity: ☐ Mild ☐ Moderate ☐ Severe

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Severity: ☐ Mild ☐ Moderate ☐ Severe

Psychiatric Diagnoses:

Are psychotropic medications prescribed? If Yes, please attach the list. ☐ Yes ☐ No

Number of ER visits in the last 30 days: **Number of psychiatric admissions in the last 6 months:**

Guardian Name: **Phone:**

Guardian Type: ☐ Private Guardian ☐ BGS ☐ No Guardian

Please submit the following documents with this form (if available):

☐ Current Service Plan ☐ Functional Behavior Assessment ☐ Behavior Support Plan

☐ Current Psychological Evaluation ☐ Current Psychiatric Evaluation ☐ Risk Assessment or Social History

☐ Applicable Data Sheets

** Please upload the completed referral to I-record after submission to the Resource Team**