

Referral Date:

Specialized Needs Unit (SNU) Referral Form

Aurora's Specialized Needs Unit (SNU) is designed to meet the needs children and adolescents ages 8-17 years old diagnosed with Intellectual/Developmental Disabilities (I/DD) experiencing acute behavioral crisis. Our 30–45-day hospitalization provides wrap-around treatment to address behavioral issues that impede daily functioning. Our mission is to successfully reintegrate patients back into their home and community using a combination of behavior analysis and specialized psychiatric care.

Due to the intensive nature of the program, it is essential that each referral form is filled out in its entirety, and that all supporting documentation is included at the time of referral. Please see below for our referral checklist to ensure all items are included prior to sending the referral:

Required documentation for complete referral:

- Completed SNU referral form.
- Recent psychiatric notes (e.g. psych note, prog note).
- Recent clinical notes indicating need for inpatient care.
- Documentation supporting an intellectual/developmental disability.

Examples include:

- Evaluation and/or testing from a psychologist, psychiatrist, school psychologist, neuropsychologist.
- IEP/MET that includes a summary of evaluations supporting the diagnosis.
- Past and current medication list.

* If sending supporting documents as one file, please indicate the starting page number for each section when sending the referral.

Please complete the following information:

Who is making this referral?

Name:

Phone:

Email:

Please send completed referrals and any supporting documents to our SNU admission team:

Aurora.SNU@aurorabehavioral.com

Once received, our clinical teams will review the referral within 24-72 hours and will reach out if any additional information is needed. Once approved by our treatment team, Aurora will seek authorization via the insurance information provided. Once authorized, admission to the unit will be pending current bed availability. Once a bed is available, the SNU admissions team will contact the guardian to schedule an admission.

If you have any questions about the referral process, please contact us at our 24/7 admissions line:

480.345.5420

Specialized Needs Unit (SNU) Referral Form

Demographics

Patient Name:

Gender:

Age:

Height:

Weight:

Primary Language Spoken:

Date of Birth:

Where is the patient at the time of referral?

Family Home

Group Home

Residential Treatment/Hospital

If checked, which facility?

Is the patient currently in DCS custody?

Yes

No

Legal Guardian(s):

Name: Relationship:

Phone:

Email:

Name: Relationship:

Phone:

Email:

Primary Caregiver(s):

Name: Relationship:

Phone:

Email:

Name: Relationship:

Phone:

Email:

What is the patient's permanent address?

Address: City: State: Zip:

Family Home

Group Home

Other:

Insurance Provider (Primary):

Policy Number:

Insurance Provider (Secondary):

Policy Number:

Clinical

Reason for referral:

Type of behaviors occurring and frequency (check all that apply):

- Physical Aggression: Daily Weekly Monthly
- Verbal Aggression: Daily Weekly Monthly
- Property Destruction: Daily Weekly Monthly
- Self-Injury: Daily Weekly Monthly

Who are these behaviors primarily directed at? (Check all that apply)

- Family members School staff Peers Self

Has the patient ever been considered a perpetrator or victim of sexually acting out behaviors?

- Yes No

- Perpetrator Victim

If yes, please indicate the frequency in which these behaviors occurred.

- Single Incident Multiple Incidents Ongoing Concern

If yes, who have these behaviors involved?

- Family Members School Staff Peers Service Provider

Please provide any additional details below:

Is the patient currently experiencing any legal issues? Yes No

If yes, please provide additional details:

What are the primary treatment goals:

Diagnosis:

Please indicate all listed diagnoses as indicated by the patient's medical records.

Dx Code

Diagnosis

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Discharge Planning: What placement will the patient be discharged to?

Plan A: Family Home Group Home Other:

Plan B: Family Home Group Home Other:

Who will participate in SNU caregiver training:

Family members Group Home Staff Other:

Medical

Check all that apply:

Seizure disorder Diabetes Fall Risk Hearing Impairments N/A

Other/Ongoing medical care required:

Allergies:

Does patient have history [~~A~~ seizures? Yes No

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How often do seizures occur?

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When was the last seizure?

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Does patient see a Neurologist? Yes No When was their last appointment? mm/dd/yyyy

What medications is the patient on specifically for seizures?

Neurologist name and contact number?

Dependent Care Needs

Please choose the option that best describes the patient’s ability to complete the following tasks:

- Independent: The patient does not require any assistance from others to complete the task.
- Prompted: The patient can complete tasks themselves, with verbal prompting and directions.
- Assisted: The patient requires physical help to complete the task from a caregiver/staff member.

Check all that apply:

Showering: Independent Prompted Assisted

Toileting: Independent Prompted Assisted

Pull-ups: Yes No Day Night

Diaper: Yes No Day Night

Speech: Full verbal Partial verbal Non-verbal

Additional Info (e.g. receives speech services, utilizes a communication device):

Provider Contacts

Behavioral Health Case Manager

Name: Phone: Email:

DDD Case Manager

Name: Phone: Email:

Primary Care Physician

Name: Phone: Email:

Other (e.g. medical specialist)

Name: Phone: Email:

Type of provider:

Medication:

Please list any medications that the patient is currently taking. Include non-prescription medications & vitamins or supplements:

| Name of Medication: | Dose: (strength and number of times per day) | When did this medication start? |
|---------------------|--|---------------------------------|
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Past Medications

Please list any medications that the patient has previously taken. Please include non-prescription medications & vitamins or supplements:

| Name of Medication: | Dose: (strength and number of times per day) | When did this medication start/end? |
|---------------------|--|-------------------------------------|
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Additional Information: