Individual Review / Technical Assistance Request Form

☐IR ☐ Specialized Training ☐ Bio-Timeline ☐ _____

Phone: (814) 728-9400 Fax: (814) 728-8887 Email: IR@MilestonePA.org

Date of Request: _____

Initials and MCI # of Individual: _____ DOB: _____/_____/_____

Individual's Address: _____

County of Residence: _____ County of Registration: _____

Living Status: ☐ Residential ☐ Life-Sharing ☐ Family ☐ Independent ☐ Personal Care Home
☐ Other _____

Individual's Provider Agency: _____

Phone: (_____)_____-_____ Contact Person: _____

Please list all significant diagnoses:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Please check all concerns precipitating this request:

☐	Confusion, difficulty communicating	☐	Indications of Pain (ex. Grimacing, guarding, limping)
☐	Falls/balance issues	☐	Rashes/skin infections
☐	Staring episodes, convulsions	☐	Neurovegetative changes (sleep, appetite, energy level)
☐	Change in bowel/bladder habits	☐	Cognitive changes (ex. concentration/attention, memory)
☐	Edema/swelling	☐	Mood changes (ex. sadness, mood swings, irritability)
☐	Weight gain/loss	☐	Behavioral changes (onset, increase, decrease)
☐	Respiratory symptoms (ex. shortness of breath)	☐	Decreased ability to self-care
☐	Gait changes, decreased motor coordination (change in ambulatory status)	☐	Perceptual changes (ex. Hallucinations, delusions, racing thoughts)

Please provide any additional information: _____

_____

What resources have already been accessed?

☐ ICM ☐ DDTT ☐ Psychiatric hospitalization ☐ WPIC/Merck Program
☐ CSRU ☐ Medical hospitalization ☐ Rehab/therapy
☐ Other _____

What has been tried thus far to resolve or improve the situation (please be specific and explain in detail)?

_____

_____

_____

What are the team's expected outcomes of this review?

_____

_____

_____

_____

Who else do you anticipate will attend and contribute to this review (ex. Program Specialist, family member (s), Behavior Specialist, etc.)?

Name	Role
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

In order to expedite the process, please provide dates over the next month that the above team members are available for a meeting with HCQU staff (plan for about two hours).

_____	_____	_____	_____
_____	_____	_____	_____

Please include with referral (via email or mail):

- ☐ Most updated ISP
- ☐ Most current Lifetime Medical History (if applicable)
- ☐ Current medication list
- ☐ Medication history for the past year
- ☐ Psychological and/or psychiatric evaluations (if applicable)

Supports Coordinator Initiating request: _____

Phone: _____ Fax: _____

Email: _____

Please designate how you prefer to receive the Letter of Suggestions:

☐ Email ☐ Fax ☐ Mail

Supports Coordinator Signature: _____