STATE OF TENNESSEE
DEPARTMENT OF INTELLECTUAL AND DEVELOPMENTAL DISABILITIES
INTAKE REFERRAL FORM

DATE: _____ **STAFF PERSON COMPLETING FORM:** _____

INITIAL CONTACT BY: ☐ Telephone ☐ Fax ☐ Email ☐ Walk-in ☐ Mail

REFERRED BY: ☐ DCS ☐ ICF/MR ☐ MHI ☐ APS ☐ Nursing Home
☐ Judicial System ☐ School System ☐ Other:_____

Check if the person is currently receiving services through any of the following:
☐ DCS ☐ ICF/MR ☐ DIDD State Funded Srv. ☐ Mental Health Facility ☐ Judicial System ☐ Choices

I. Information about the individual needing services:

Last Name:	First Name:	Middle Initial:
Address (Street, City, State, Zip) Special Mailing Accommodations/Instructions:		

County:	D.O.B:	Age:	SSN:
Phone Numbers: Home:	Work:	Cell:	

Is there a diagnosis of Mental Retardation Prior to age 18? (If yes, documentation must be provided)
☐ Yes ☐ Confirmed (date) _____
☐ No
☐ Age 0-5 with high probability of MR ☐ Age 0-5, No diagnosis

Gender: ☐ Male ☐ Female	Race ☐ American Indian ☐ Asian/ Pacific Islander ☐ Black/African American ☐ Hispanic ☐ Caucasian/White ☐ Other, specify:_____

II. Information about the primary contact person (e.g., parent, guardian/ conservator, family member):

Last Name:	First Name:
Address (if different than above) Special Mailing Accommodations/Instructions:	

Phone Numbers: Home:	Work:	Cell:

Relationship to individual: ☐ Self ☐ Parent ☐ Sibling ☐ Friend ☐ Conservator/Guardian*
☐ Other Relative: ☐Other, specify:

*If Conservator/Guardian, please note that a copy of the Court Orders will be needed.