

**Developmental Disabilities Program
Behavior Consultation Team Services
Referral Form**

Step 1: Referral Process

Please complete the form and fax to the Behavior Consultation Team member in your area. You may also access services via telephone or Therap, in which case the BCT member will complete the form with you.

Step 2: Individual Information

Today's Date: [Click here to enter a date.](#)

Person being referred:

Date of Birth:

Age:

AWACS #:

Address:

Phone:

Is this person their own guardian? Yes No (if no, please provide the following:

Guardian name:

Address/phone:

Brief reason for the referral & pertinent information (You will be able to provide more information when the Behavior Consultation Professional contacts you):

What are the most urgent concerns at this time? (Check all that apply)

- Physical harm towards others
- Physical harm towards self
- Emotional harm towards others
- Harm by others
- Property destruction
- Elopement/leaving without notification
- Worsening psychiatric symptoms
- Worsening/escalating behavior(s)
- Sexual offending behavior(s)
- Significant impact on caregiver/support staff/family
- Other (e.g., law enforcement involvement)

Is this person currently in the hospital or other inpatient treatment facility? Yes No

What interventions have been attempted to stabilize the situation?

What is the desired outcome of this consultation?

Note: If this is a psychiatric, behavioral, or medical emergency contact the person's physician or call 911.

**Developmental Disabilities Program
Behavior Consultation Team Services
Referral Form**

Step 3: Other Information

Referred by:
Relationship:
Address:
Phone:

Type of Residential Supports:

- Supported living services
- Group home
- Independent living
- Foster home
- Family home
- Respite
- None
- Other

Provider agency:
Contact Person:
Phone:

Case Management Information

Case Manager:
Agency:
Address:
Phone:

Medical & Psychiatric Information

Level of intellectual disability: Mild Moderate Severe Profound
Other conditions: Autism spectrum disorder Cerebral palsy TBI Other:

Primary Psychiatric Diagnosis:

Psychiatric Provider:

Primary Medical Diagnoses:

Medical Specialists:

Other conditions:

- Seizure disorder Neurologist:
- Allergies Type:
- Sleep difficulties Swallowing difficulties Appetite changes Headache
- Change in energy level Other:

Check yes or no for the following:

Previous psychiatric hospitalization?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Previous residential treatment facility placement?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has a Functional Behavior Assessment been completed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does the person have a Behavior Support Plan?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

**Developmental Disabilities Program
Behavior Consultation Team Services
Referral Form**

Is this person receiving medications? Yes No

If yes, list all medications including over-the-counter and supplements:

BCT Contact Information

Supervisor:

Connie M. Orr, M.A., NADD-DDS
Helena Office
Phone: (406)444-3072 or (406)431-0248
Fax: (406)444-0230
Hours: Mon – Fri 8:00AM – 5:00PM

Behavior Consultation Specialists:

Nathan Dudley, M.A.
Helena Office
Phone: (406) 444-6904 or (406)438-6966
Fax: (406)444-0230
Hours: Mon – Fri 8:00AM – 5:00PM

Cheryl Nystrom-Ryckman
Billings Office
Phone: (406)655-7696 or (406)422-8267
Fax: (406)652-1895
Hours: Mon – Fri 8:00AM – 5:00PM

Behavior Intervention Specialists:

Kelli Caballero, MSW
Missoula Office
Phone: (406)329-5434 or (406)560-5644
Fax: (406)329-5490
Hours: Th – Mon 2:00PM – 10:00PM

McKenzie Lyons
Great Falls Office
Phone: (406)454-6083 or (406)781-0367
Fax: (406)454-6082
Hours: Th – Mon 2:00PM – 10:00PM

NOTE: Hours may change based upon the needs of the person and/or provider agency/family

Team Member Notifications

Provider agency notified and agrees to referral:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Click here to enter a date.
Case Manager notified and agrees to referral:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Click here to enter a date.
Family/guardian notified and agrees to referral:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Click here to enter a date.
QIS notified and agrees to referral:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Click here to enter a date.
Individual notified and agrees to referral:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Click here to enter a date.
Regional manager notified:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Click here to enter a date.
Case Management Supervisor notified:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Click here to enter a date.
BCT Supervisor notified:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Click here to enter a date.

Other notifications: