# State of Connecticut





# Department of Developmental Services

**DEFERRED, LIMITED, and/or DECLINED CARE**

**REVIEW FORM**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Name: |  | Date: |  | DDS #: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Provider Name: |  | Name/Contact for Conservator/Guardian: |  |

**Guiding Standard (#09-2):** The team supporting the person with intellectual/developmental disabilities shall review all decisions to defer, limit or decline preventive and/or recommended health care and identify a plan to advocate for, educate, and/or support the person as necessary to promote his/her health and safety. After more than one decision to defer, limit, or decline health screenings or care, an identified team member should notify the regional Health Services Director/ Public Service Nursing Director of this matter so that the implications can be reviewed and a **plan can be recommended to the person’s support team.**

This form is completed by a member of the support team and submitted to the regional Health Services Director /Director of Nursing , Public Programs whenever **health screenings and/or care is deferred more than one time.**

1. Specific type of care deferred, limited, or declined:
2. Date(s) care was deferred, limited or declined:
3. Identify the specific reason for this care (e.g. routine screening, diagnostic, etc):
4. Name and role of the individual that contacted the provider to determine the reason for deferral or limitation and the date contact occurred:
5. Describe below the rationale provided by the provider for the deferral or limitation of care.

1. Describe below the **specific risk(s)** associated with the deferral of the care **for this specific individual.**

1. Describe below the actions the team has taken so far to remedy this issue (e.g. education provided to the provider, identified someone who could provide a second opinion, etc).

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Completed by:** |  | **Title:** |  | **Phone:** |  | **Date:** |  |

**Health Services Director/Director of Nursing Recommendations (completed by the Regional HSD/DON):**

|  |  |  |  |
| --- | --- | --- | --- |
| **Health Services Director/Director of Nursing Signature:** |  | **Date:** |  |