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|  | | | | | | | | | | | | Date of Referral: | | | |  |
|  | | | | | | | | | | | | Individual Making Referral: | | | | Name: |
|  | | | | | | | | | | | | Address: | | | | |
|  | | | | | | | | | | | | Phone number: | | | | |
|  | | | | | | | | | | | | Additional contact information: | | | | |
| Adult and elderly referral | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | |
| Name (Last, First, M.I.): |  | | | | | | | M  F | | DOB: | | |  | | | |
| Marital status: | | | Single  Partnered  Married  Separated  Divorced  Widowed | | | | | | | | | | | | | |
| Address: | | | | |  | | Phone Number: | | | | | | | |  | |
| Current Location: | | | | |  | | Expected length of stay: | | | | | | | |  | |
| Services arranged for discharge: | | | | |  | | Discharge date: | | | | | | |  | | |
| Income Source(s): | | | | |  | |  | | | | | | |  | | |
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|  | | | | | | | | | | | | | | | | |
|  | 🞎 Guardian 🞎 Rep Payee 🞎 POA-HC 🞎 POA-F 🞎 POA-HC **Activated** Name       Contact Information | | | | | | | | | | | | | | | |
| Diagnosis | | | | mental illness | |  | alzheimer’s | | | |  | | | | | |
|  | | | | cognitive delays | |  | other (please specify) | | | |  | | | | | |
|  | | | | dementia | |  | other (please specify) | | | | | | |  | | |
| Reason for current referral: | | | | | | | | | | | | | | | | |
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| Previous referrals: | | | | | | | | | | | | | | | | |
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| Known providers and additional contacts | | | | | | | | | | | | | | | | |
| Name | | Address/Affiliation | | | | | | | Phone Number | | | | | | | |
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| Current Medications | | | | | | | |
| Drug | | Purpose | Frequency Taken | | | | |
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| Independence | Is the identified individual competent to make their own decisions? | | |  | Yes |  | No |
| Is the individual independent with their activities of daily living (showering, dressing, toileting)? | | |  | Yes |  | No |
| Does the individual make appropriate and safe decisions? | | |  | Yes |  | No |
| Is the individual independently mobile? | | |  | Yes |  | No |
| Does the individual take medications appropriately as recommended? | | |  | Yes |  | No |
| Residence | Does the individual have access to water and electricity available? | | |  | Yes |  | No |
| Is the home habitable? | | |  | Yes |  | No |
| Does the individual live alone? | | |  | Yes |  | No |
| If no list others in the household: | | |  |  |  |  |
| Does the individual have access to food and water? | | |  | Yes |  | No |
| Is the individual capable of using a phone independently? | | |  | Yes |  | No |
| Does the individual have frequent falls? | | |  | Yes |  | No |

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|  |
| Other services currently in place |
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|  | Social Worker |  | Social Worker |  | Home Health Nurse: |
|  | ADRC |  | Meals on Wheels |  | Life Line |
|  | Assisted Living |  | Nursing Home |  | Other (specify) |

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| Reason for aps invovement needed |
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|  | Self-Neglect |  | Financial Exploitation |  | Neglect by Other(s) |
|  | Emotional Abuse |  | Physical Abuse |  | Sexual Abuse |
|  | Treatment without Consent |  | EPP |  | Other |

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| Alleged Abuser Information (if applicable) | | |
| Name | Address | Phone Number |
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