|  |  |  |
| --- | --- | --- |
|  | 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): |  |  |  |
|  |
|  |
|  |
|  | 🞎 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: |
|       |
|  |
|  |
|  |
| Previous referrals: |
|       |
|  |
|  |
|  |
| Known providers and additional contacts |
| Name | Address/Affiliation | Phone Number |
|       |       |       |
|       |       |       |
|       |       |       |
|       |       |       |
|       |       |       |
|  |

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| --- |
| Current Medications |
| Drug | Purpose | Frequency Taken |
|       |       |       |
|       |       |       |
|       |       |       |
|       |       |       |
|       |       |       |
|  |
|  |
| 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 |

|  |
| --- |
|  |
| Other services currently in place |
|  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| [ ]  | Social Worker       | [ ]  | Social Worker       | [ ]  | Home Health Nurse:       |
| [ ]  | ADRC       | [ ]  | Meals on Wheels       | [ ]   | Life Line       |
| [ ]  | Assisted Living       | [ ]  | Nursing Home       | [ ]  | Other (specify)       |

|  |
| --- |
| Reason for aps invovement needed |
|  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| [ ]  |  Self-Neglect       | [ ]  |  Financial Exploitation      | [ ]  | Neglect by Other(s)       |
| [ ]  | Emotional Abuse       | [ ]  | Physical Abuse       | [ ]   | Sexual Abuse       |
| [ ]  | Treatment without Consent       | [ ]  | EPP       | [ ]  | Other       |

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