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| Logo  Description automatically generated | EXCLUSIVE CARING PARTNERS**PROVIDER REFERRAL / INTAKE FORM** |
| **This referral form is meant to be used by medical and professional providers and other agencies, organizations and professionals seeking to initiate residential services for clients in their care. If you have any additional documentation you wish to share concerning a referred client, please attach to this form and fax directly to Exclusive Caring Partners at (980) 207-4791. If you wish to fax a referral form, please use this referral form format (PDF). All information submitted on this referral form is completely confidential, secure, and encrypted. After you submit the referral form, you will be emailed a copy for your records.** |
|  |  |  |  |  |  |
| **CLIENT INFORMATION** |
| **First Name:**       | **Last Name:**       | **Suffix:**       |
| **Birthdate:**       | **Age:**       |  |  |  |
| **Client’s Gender**: [ ]  Male [ ]  Female [ ]  Other | **Client’s Preferred Pronouns**: Choose an item.  |
| **Client’s Race:** Choose an item. | **Client’s Social Security #:**       |
| **Marital Status:**  | [ ]  Single | [ ]  Married | [ ]  Divorced | [ ]  Other       |
| **Primary Language:** | [ ]  English | [ ]  Spanish | [ ]  Other       |  |  |
| **Religious Preference/Affiliation:**       |  |  |
|  |  |
| **Guardian Status:** | [ ]  None (Self) [ ]  General Guardian [ ]  Guardian of Person [ ]  Guardian of Estate |
| **Guardian Name:** |       |  |  |  |  |
| **Guardian Address:** |       |  | **City:**       | **State:**       | **Zip:** |
| **Guardian Phone:**  |       | Choose an item. | **Guardian Email:** |       |  |
|  |  |  |  |  |  |
| **Client Address:** |       |  | **City:**       | **State:**       | **Zip:**       |
| **Client Phone:**  |       | Choose an item. | **Client Email:** |       |  |
| **Preferred Method of Contact:** | Choose an item. |  |  |  |
|  |  |  |  |  |  |
| **Type of Insurance:** | Choose an item. | **If Other – Specify:** |       |  |
| **If Medicaid – Which County/MCO?**       | **Insurance ID #** |       |  |
|  |  |  |  |  |  |
| **Referral Name:** |       | **Referring Agency/Office/Organization:**       |
| **Referral Title:** |       | **Referral Email:** |       |
| **Referral Phone:** |       | **Referral Fax #:** |       |
|  |  |  |  |  |  |
| **LME/MCO:** |       | **Case Manager Name:**       |
| **Case Manager Phone:**       | **Case Manager Email:**       |
|  |  |  |  |  |  |
| **CLIENT MEDICAL INFORMATION** |
| **Height:**       | **Weight:**       | **Hair Color:**       |
| **Eye Color:**       | **Identifying Marks:**       |
| **Allergies:**       |
|  |  |  |  |  |  |
| **Services Needs/Services Provided:** | [x]  AFL | [ ]  GH – Waiver | [ ]  GH – ICF/IID | [ ]  GH – Residential Support |
| **Level of MR:** | [ ]  Mild | [ ]  Moderate | [ ]  Severe | [ ]  Profound | [ ]  MR/MI |
| **Adaptive Level:** | [ ]  Mild | [x]  Moderate | [ ]  Severe | [ ]  Profound | [ ]  None Indicated |
| **Mental Health Diagnosis:**       |
| **Behavioral Concerns:** | [ ]  Self-Injurious | [ ]  Sexual Perpetrator | [ ]  Aggression Towards Others |
|  | [ ]  Intermittent Explosive Disorder | [ ]  Aggression Toward Property |
|  | [ ]  PICA | [ ]  Other       |

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| **Related Conditions:** | [ ]  Acquired Brain Injury | [x]  Arthritis | [ ]  Autism | [ ]  Blind | [ ]  Cancer |
| [ ]  Cerebral Palsy | [ ]  Chronic Constipation | [ ]  Chronic Hip Dislocation | [ ]  Chronic Otitis Media | [ ]  Congenital  Heart Defect |
| [ ]  CongenitalHip Dislocation | [ ]  Kidney Dialysis | [ ]  Diabetes /Insulin Dependent | [ ]  Diabetes /Non-Insulin Dep. | [ ]  Tube Feeding |
| [ ]  G.E.R.D | [ ]  Seizures | [ ]  Other       |
| **Other Medical****Complexities:** |       |
| **Are physical accommodations needed?** | [ ]  Yes | [ ]  No | Specify       |
| **Communication:** | [ ]  Verbal | [ ]  Non-Verbal | [ ]  Communicateswith device | [ ]  Communicateswith gestures | [ ]  Communicateswith signs |
| [ ]  Other       |
| **Current Medications:** |       |
| **Does client have a specialized diet/diet order?** | [ ]  No | [ ]  Yes |  |
| Specify:       |
| **During mealtime, is/does the client:** |
| [ ]  Able to eat independently (with or without adaptive equipment) | [ ]  Require support to eat | [ ]  Require physical assistance or equipment |
| [ ]  Require positioning equipment | [ ]  Other       |
| **Food consistency:** | [ ]  Normal | [ ]  Altered | If altered:  | [ ]  Chopped | [ ]  Pureed |
| [ ]  Ground | [ ]  Use thickener |
|  |  |  |  |  |  |
| **Toileting** | [ ]  Able to toilet independently | [ ]  Requires physical assistance/equipment |
| [ ]  Scheduled Bowel Program | [ ]  Scheduled Bladder Program |
| [ ]  Requires Prompting/Monitoring | [ ]  Incontinent/requires disposable diapers |
| **Bathing** | [ ]  Independent | [ ]  Independent with devices | [ ]  Requires support to bathe or shower |  |
|  |
|  |  |  |  |  |  |
| **Is there any additional or relevant medical information our team should know about the client?** |
|       |
|  |  |  |  |  |  |
| **Please attach any recent psychological evaluations and other documentation that you would like our team to know.** |
|  |  |  |  |  |  |
| **Name of Person Completing this Form** | **Title of Person** |
|       |       |
| **Signature**  | **Date**       |

**\*\*\*FOR ECP STAFF USE ONLY\*\*\***

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| **Client Appropriate for ECP services** | **Disposition** | [ ]  Admit forservice | [ ]  Turned downfor service |
| [ ]  Yes | [ ]  No |  |
|  |  |  | Reason |       |
| Reviewer:       |
| Date:       |