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:		☒ AFL	☐ GH – Waiver	☐ GH – ICF/IID	☐ GH – Residential Support
Level of MR:	☐ Mild	☐ Moderate	☐ Severe	☐ Profound	☐ MR/MI
Adaptive Level:	☐ Mild	☒ 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			

Please fax completed referral forms to (980) 207-4791 OR send via email to referrals@exclusivecaringpartners.com
If you have not received a response from our referral team within 3 business days,
please call our referral team directly at (704) 886-6680 or referrals@exclusivecaringpartners.com.

Related Conditions:	☐ Acquired Brain Injury	☒ Arthritis	☐ Autism	☐ Blind	☐ Cancer
	☐ Cerebral Palsy	☐ Chronic Constipation	☐ Chronic Hip Dislocation	☐ Chronic Otitis Media	☐ Congenital Heart Defect
	☐ Congenital Hip 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	☐ Communicates with device	☐ Communicates with gestures	☐ Communicates with signs
	☐ Other				
Current Medications:					
Does client have a specialized diet/diet order?			☐ No Specify:	☐ Yes	

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 ☐ Ground	☐ Pureed ☐ 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*****

Client Appropriate for ECP services
☐ Yes ☐ No

Disposition ☐ Admit for service ☐ Turned down for service

Reviewer:
Date:

Reason

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