



# 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.

<b>CLIENT INFORMATION</b>			
First Name:	Last Name	Suffix:	
Birthdate:	Age:		
Client's Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other	Client's Preferred Pronouns:	Choose an item.	
Client's Race: Choose an item	Client's Social Security #:		
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Other			
Primary Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other			
Religious Preference/Affiliation:			

Guardian Status: <input type="checkbox"/> None (Self) <input checked="" type="checkbox"/> General Guardian <input type="checkbox"/> Guardian of Person <input type="checkbox"/> Guardian of Estate
Guardian Name:
Guardian Address: City: State: NC Zip:
Guardian Phone: Mobile Guardian Email:

Client Address: City: Charlotte State: NC Zip:
Client Phone: Home Client Email:
Preferred Method of Contact: Home

Type of Insurance: Medicaid If Medicaid – Which County/MCO?	If Other – Specify: Insurance ID #
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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:

<b>CLIENT MEDICAL INFORMATION</b>		
Height:	Weight:	Hair Color:
Eye Color:	Identifying Marks:	
Allergies:		

Services Needs/Services Provided: <input type="checkbox"/> AFL <input type="checkbox"/> GH – Waiver <input type="checkbox"/> GH – ICF/IID <input type="checkbox"/> GH – Residential Support
Level of MR: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Profound <input type="checkbox"/> MR/MI
Adaptive Level: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Profound <input type="checkbox"/> None Indicated
Mental Health Diagnosis:
Behavioral Concerns: <input type="checkbox"/> Self-Injurious <input type="checkbox"/> Sexual Perpetrator <input type="checkbox"/> Aggression Towards Others
<input type="checkbox"/> Intermittent Explosive Disorder <input type="checkbox"/> Aggression Toward Property
<input type="checkbox"/> PICA <input type="checkbox"/> Other

Please fax completed referral forms to (704) 396-6522 OR send via email to [referrals@exclusivecaringpartners.com](mailto: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](mailto:referrals@exclusivecaringpartners.com).

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<b>Related Conditions:</b>	<input type="checkbox"/> Acquired Brain Injury	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Autism	<input type="checkbox"/> Blind	<input type="checkbox"/> Cancer
	<input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> Chronic Constipation	<input type="checkbox"/> Chronic Hip Dislocation	<input type="checkbox"/> Chronic Otitis Media	<input type="checkbox"/> Congenital Heart Defect
	<input type="checkbox"/> Congenital Hip Dislocation	<input type="checkbox"/> Kidney Dialysis	<input type="checkbox"/> Diabetes / Insulin Dependent	<input type="checkbox"/> Diabetes / Non-Insulin Dep.	<input type="checkbox"/> Tube Feeding
	<input type="checkbox"/> G.E.R.D	<input type="checkbox"/> Seizures	<input type="checkbox"/> Other		

**Other Medical Complexities:**

**Are physical accommodations needed?**     Yes     No    Specify

**Communication:**

<input type="checkbox"/> Verbal	<input type="checkbox"/> Non-Verbal	<input type="checkbox"/> Communicates with device	<input type="checkbox"/> Communicates with gestures	<input type="checkbox"/> Communicates with signs
<input type="checkbox"/> Other				

**Current Medications:**

**Does client have a specialized diet/diet order?**     No     Yes  
Specify:

**During mealtime, is/does the client:**

<input type="checkbox"/> Able to eat independently (with or without adaptive equipment)	<input type="checkbox"/> Require support to eat	<input type="checkbox"/> Require physical assistance or equipment
<input type="checkbox"/> Require positioning equipment	<input type="checkbox"/> Other	

**Food consistency:**     Normal     Altered    If altered:     Chopped     Pureed  
 Ground     Use thickener

**Toileting**

<input type="checkbox"/> Able to toilet independently	<input type="checkbox"/> Requires physical assistance/equipment
<input type="checkbox"/> Scheduled Bowel Program	<input type="checkbox"/> Scheduled Bladder Program
<input type="checkbox"/> Requires Prompting/Monitoring	<input type="checkbox"/> Incontinent/requires disposable diapers

**Bathing**

<input type="checkbox"/> Independent	<input type="checkbox"/> Independent with devices	<input checked="" type="checkbox"/> Requires support to bathe or shower
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**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.

<b>Name of Person Completing this Form</b>	<b>Title of Person</b>
<b>Signature:</b>	<b>Date:</b>

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

<b>Client Appropriate for ECP services</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Disposition</b>	<input type="checkbox"/> Admit for service	<input type="checkbox"/> Turned down for service
Reviewer:		Reason:		
Date:				

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