|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | | **Referral Form** | | | | | |
| **Support Coordinator:** | |  | | | | | |
| **Agency:** | |  | | | | | |
| **Address:** | |  | | | | | |
| **Telephone Numbers** | | **Home:** |  | **Office:** |  | **Pager/ Mobile:** |  |
| **Consumer:** | |  | | | | | |
| **Date of Referral:** | |  | | | | | |
| **Tentative Move-in Date:** | |  | | | | | |
| **District/ Region:** | |  | | | | | |
| **Checklist for Referral Packet** | | | | | | | |
|  | Completed Residential Placement Referral form. | | | | | | |
|  | Copy SIS (If, available) | | | | | | |
|  | Current Support Plan | | | | | | |
| **Additional documents as follows:** | | | | | | | |
|  | Psychological Evaluations | | | | | | |
|  | Psychiatric Evaluations | | | | | | |
|  | Critical Medical Reports | | | | | | |
|  | Skills Assessments | | | | | | |
|  | Behavioral Assessments | | | | | | |
|  | Other (Specify) | | | | | | |

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| **1. Consumer:** | |  | | | | | | | | | | **Age:** | |  | | **DOB:** | | |  |
| **2. Legally Competent Adult:** | | | | |  | **Yes** |  | | **No** | |  | | | | | | | | |
| **If no, guardian’s name, and relationship** | | | | |  | | | | | | | | | | | | | | |
| **3. Next of Kin:** | | | | |  | | | | | | | | | | | | | | |
| **4. Reason for Current Referral (brief History, description of current situation and presenting problems:** | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | |
| **5. Level of Mental Retardation/ICD-10 Code if applicable:** | | | | | | | | | | | | | | | | | | | |
|  | **Mild** | | |  | **Severe** | | |  | | **Moderate** | | | | |  | | **Profound** | | |
| **6. Important Medical issues (describe, if any, i.e., seizure disorder, heart problems, diabetes, hypertension, etc.):** | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | |
| **Ambulation status:** | | |  | | | | | | | | | | **Height:** | | | | |  | |
| **Allergies:** | | |  | | | | | | | | | | **Weight:** | | | | |  | |
| **Special Diet:** | | |  | | | | | | | | | | | | | | | | |
| **Vision:** | | |  | | | | | | | | | | **Hearing:** | | | | |  | |
| **6. Physical Handicaps (describe, if any):** | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | |

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| **7. Behavioral Issues (Describe, if any, i.e., non-compliance, verbal aggression, physical aggression, etc. Identify any significant behaviors which could pose a risk to other residents in a group setting.):** |
|  |
| **8. Previous Residential Placement History if available, provide facility names, dates of placements, and reason(s) for withdrawal):** |
| |  |  |  |  | | --- | --- | --- | --- | | **9. Adaptive Skills Assessment** (Check appropriate column): | | | | |  | **Independent** | **Requires Assistance** | **Dependent** | | **Basic Skills** |  |  |  | | **Eating** |  |  |  | | **Toileting** |  |  |  | | **Personal Hygiene** |  |  |  | | **Dressing** |  |  |  | | **Receptive Communication** |  |  |  | | **Expressive Communication** |  |  |  | | **Ability to Evacuate** |  |  |  | | **Comments:** | | | | |  | | | | |