Service Provider Referral Form
Day Services/Memory Care

Received: Click or tap to enter a date.

Please complete to the best of your ability. If the information is unknown, please indicate this by writing unknown.

Person making referral:	**Agency:**
Member Contact Information	
Member's Name:	**Date of Birth:**
Address: _____ **City:** _____ **State:** _____	**Age:** **Gender:** **Preferred Language:** **If other than English, is a translator required?** ☐ **- Yes** ☐ **- No**
Phone number:	**Relationship status:**

Guardian Information		
Does member have a guardian? ☐ **Yes** ☐ **No**	**Guardian Contact Address:** **Street:** _____ **City:** _____ **State:** _____	**Guardian Phone Number:** **( ) -**

Income Type:		
☐ **Social Security** ☐ **SSDI**	☐ **SSI** ☐ **Employment Income** ☐ **Death Benefits**	☐ **SSIE** ☐ **Unemployment- related benefits**

Living Arrangements:		
☐ **Lives independently** ☐ **Lives with family** ☐ **Lives with partner/spouse**	☐ **Lives with roommate** ☐ **Lives in group home** ☐ **Lives in a supported community**	☐ **Lives in Adult Family Home** ☐ **Other (specify) -** _____

Housing Type:

☐ **- Owns home**
☐ **- Rents home/ apartment/ duplex**
☐ **- Rents room**
☐ **- Lives with care provider**
☐ **- Other, please explain:**

Transportation	
☐ - **Drives/owns car**	☐ - **Walk**
☐ - **City bus**	☐ - **Cab/taxi service**
☐ - **Bicycle**	☐ - **Other (family, roommate, care provider, etc.)**

Natural Support Involvement:

Contact person/relationship	Address	Phone number

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Agency Involvement:

Contact person/agency	Address	Phone number

Legal Involvement:

Is member protectively placed?

☐ - Yes ☐ - No

Does member have active charges against them (misdemeanor/felony)?

☐ - Yes ☐ - No

Please Explain:

Please explain past criminal history (if applicable):

Please explain any past/ current drug/ alcohol use:

Medical Conditions (including disability diagnosis):

List medical conditions:

- _____
- _____
- _____
- _____

List of disability diagnosis:

- _____
- _____
- _____
- _____

Please list any mental health concerns/ diagnoses:

Physician (Ophthalmologist, Primary Physician, Dentist, Audiologist, Mental Health Specialists, etc.).

Physician name	Specialty	Clinic

Medications

List medications:	Purpose of Medications:
_____	_____
_____	_____

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_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Assistive Devices

Does the member use any devices such as walker, wheelchair, cane, hearing aids, incontinence briefs?
What type of device does the member require?

Behavioral, Legal and Safety Concerns/Issues:

☐ Aggressive toward others ☐ Aggressive toward self ☐ Puts objects in mouth ☐ Recent self harm ☐ Past self harm ☐ Recent suicide attempts ☐ Past suicide attempts	☐ Recent suicide thoughts ☐ Inappropriate language ☐ Personal boundaries ☐ Any sexual behaviors ☐ Sexually acting out ☐ Any drug or alcohol use ☐ Drug overdose history ☐ Destroys property	☐ Flight risk ☐ Repetitive behaviors ☐ Pending legal issues ☐ Legal involvement (Juvenile Detention, Probation, Parole, Incardination History).	☐ Outbursts ☐ Hyperactive ☐ Weapons in home ☐ Weapons secure ☐ Poor coordination/balance

Further explain behavioral, legal and safety concerns:

Allergies:

Does the member have allergies? ☐ Yes ☐ No
Please explain allergy (if applicable):

Purpose of Referral:

Reason referral is being made:

Referred By:

Name of Community Resource Coordinator/IRIS Consultant:
Signature of Community Resource Coordinator/IRIS Consultant: _____

Address:

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Phone:	**Email:**
Name of Family Care or IRIS Agency:	