Placement Referral

Individual Making the Referral, Email Address:_______________________________________

Referral Information

Full Name of Individual First________________________ Last_____________________

Gender: _____________________________

Present Address: Street Address:____

City:____________________State_____ Zip Code:________________

Currently In Hospital: Yes:_________ No:__________

If Yes: Hospital Name:____

Date of Birth:____

Phone Number:____

M.A. Number:____

Waiver Type:____

If No Waiver, Date of Anticipated Screening:____________________

Services Desired: Adult Foster Care:_______________ 24 Hour Supervision Yes____ No___
ILS:____________________________ Weekly Support Hours:___________
Other:____

Case Manager Information

Case Manager Name: First:_________________________ Last:___________________________

County or Agency Name:____

Case Manager Address: Street Address:____

City:____________State:_________Zip Code:_______

County of Financial Resposibility:____

Medical Information

Psychiatrist:________________________________ Agency:____________________________

Street Address:____

City:________________________________State:_________________Zip:________________

Psychiatrist Phone Number:____

Diagnosis: ____

____

____

____

____

Primary Medical Doctor:____________________________Agency:_________________________

Street Address:____

City:________________________________State:___________________Zip:______________

Primary Doctor Phone Number:____

Medical Conditions:____

____

____

____

Hospitalizations in the last 3 years: ________Inpatient Mental Health ______Inpatient Medical

Please Describe:____

____

____

____

Other Services:

Day Treatment Involvement:____

____

____

Vocational Involvement:____

____

____

Current Service Provider Information

Current Service Provider:____

Contact Person:_______________________________Phone Number:_____________________

Street Address:____

City:___________________________State:______________________Zip Code:___________

Individual Currently Under Commitment: Yes________________ No________________

IF Yes: Date and Explanation:____

____

____

Guardianship: Yes___________________ No:_________________

Rep Payee: Yes___________________ No_________________

Funding Source(s):____

____

____

Amount:____

Community Integration:____

____

____

Medical Monitoring/Education:____

____

____

____

Symptoms Management:____

____

____

____

____

Mobility Status:____

Self Care/ADL's:____

____

Gender/Sexual Issues:____

____

____

Vocational Functioning:____

Social Functioning:____

____

____

Substance Abuse:____

Medical/Dental Needs/Special Diets____

____

Does The Client Know of This Referral? Yes:_______________ No:_______________

Referred By Information

Referred By First Name:________________________ Last Name:____________________

Phone Number:__________________________

Date Completed By:____

This form will be submitted to Terrol Ferguson at terrol@paraserv.org