

**Print and fill out this form  
and fax it to (716) 849-8724**

**Referral Information**

Referral Source: \_\_\_\_\_ Type of Agency: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Applicant Name: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Resides with:  Alone  Spouse  Child  Parent Other (specify) \_\_\_\_\_

Does registrant have own keys? \_\_\_\_\_ Name Preference \_\_\_\_\_

Primary Language \_\_\_\_\_ Can Registrant be left alone?  Yes  No

DOB \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_ Marital Status \_\_\_\_\_ Social Security No. \_\_\_\_\_

**INSURANCE INFORMATION:**

Date of Insurance Verification: \_\_\_\_\_ Eligible:  Yes  No

Medicare No. \_\_\_\_\_ Part B:  Yes  No Effective Date \_\_\_\_\_

Medicaid CIN No. \_\_\_\_\_ Access No. \_\_\_\_\_

Other \_\_\_\_\_ Managed Care Program:  Yes  No

Diagnoses	Onset Date
1.	
2.	
3.	

Hospitalization (Place/Date/Reason): \_\_\_\_\_

PMD Name \_\_\_\_\_ License No. \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Date Last Seen \_\_\_\_\_ (at least 6 weeks prior to admit)

Functional Status Prior to Dx \_\_\_\_\_

Continent:  Yes  No Oriented To:  Person  Place  Time  Situation  Confused

Requires Medication/Treatments:  Yes  No

Explain \_\_\_\_\_

Special Care Needs/Equipment \_\_\_\_\_

Eval Date \_\_\_\_\_ Time \_\_\_\_\_ to \_\_\_\_\_  
 OT \_\_\_\_\_ PT \_\_\_\_\_ SW \_\_\_\_\_ RD \_\_\_\_\_ Act \_\_\_\_\_ RN \_\_\_\_\_ ST \_\_\_\_\_

Community Services Currently in Home (CHHA, LTHHCP, Waiver Program):

Aide Service \_\_\_\_\_ Phone \_\_\_\_\_

DME Vendor \_\_\_\_\_ Phone \_\_\_\_\_

Therapy Services \_\_\_\_\_ Phone \_\_\_\_\_

Service Utilization – Check All Services Needed in ADHCP:

- |                        |                          |                                 |                          |
|------------------------|--------------------------|---------------------------------|--------------------------|
| Nursing                | <input type="checkbox"/> | Social Services                 | <input type="checkbox"/> |
| Physical Therapy       | <input type="checkbox"/> | Nutrition                       | <input type="checkbox"/> |
| Occupational Therapy   | <input type="checkbox"/> | Recreation                      | <input type="checkbox"/> |
| Speech Therapy         | <input type="checkbox"/> | Ophthalmology                   | <input type="checkbox"/> |
| Audiology              | <input type="checkbox"/> | Optometry                       | <input type="checkbox"/> |
| Podiatry               | <input type="checkbox"/> | Transportation                  | <input type="checkbox"/> |
| Dental                 | <input type="checkbox"/> | Diagnostic Lab (includes x-ray) | <input type="checkbox"/> |
| Pharmacy               | <input type="checkbox"/> | Other                           | <input type="checkbox"/> |
| Mental Health Services | <input type="checkbox"/> |                                 | <input type="checkbox"/> |

Responsible Party \_\_\_\_\_

Emergency Contact #1:

Name \_\_\_\_\_ Home Phone \_\_\_\_\_

Address \_\_\_\_\_ Work Phone \_\_\_\_\_

Emergency Contact #2:

Name \_\_\_\_\_ Home Phone \_\_\_\_\_

Address \_\_\_\_\_ Work Phone \_\_\_\_\_

Transportation:  Own Car  Taxi  W/C Van

Provider Name \_\_\_\_\_ Phone \_\_\_\_\_

Additional Comments \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Referral Taken by \_\_\_\_\_ Date \_\_\_\_\_