

Referral Form

- Our purpose is to help consumers live independently at home
- Consumers must be physically unable to complete their own homemaking tasks
- Services are provided no less than 8 hours a month on a long-term basis

Form must be filled in completely in order to process. Please write "N/A" where appropriate.

1. Name of Consumer: _____ 2. DOB: _____

Name of Spouse: _____ DOB: _____

3. Address of Consumer: _____

4. Total Number in Household: _____ 5. Phone # of Consumer: _____

6. Name, Agency & Phone # of person making referral, if other than consumer:

7. Emergency Contact Name, Relationship and Phone #: (Should emergency contact be called on Consumer's behalf?)

8. (For those referring on behalf of Consumer) Does Consumer know they are being referred? _____

9. Does Consumer have less than \$50,000 in liquid assets (or less than \$75,000 for a couple?) _____

10. Does Consumer know someone who could be their homemaker? Name: _____

11. Is Consumer currently on a waitlist for a CHANGE/GOOLD Health Systems assessment? _____

Agencies/Services involved with consumer: _____

Caregiver Status:

Primary Caregiver receives help from family or friends.

Primary Caregiver is unable to continue because _____

Consumer's IADL/ADL's Performance Scale:

Place number on the line which most closely describes consumer's present performance level.

1. Independently 2. Some Difficulty 3. Great Difficulty 4. Someone else must assist

_____ Laundry

_____ Grocery shopping

_____ Meal Preparation

_____ Banking

_____ Meal Planning

_____ Picking up prescriptions

_____ Light Housecleaning
 _____ Washing floors/vacuuming
 _____ Cleaning bathtub/shower, toilet
 _____ Changing/Making bed

_____ Taking out trash
 _____ Limited Assistance with Personal Hygiene,
 such as: combing/washing hair, washing face,
 putting on jacket or shoes to go out
 Other _____

Medical Information:

<u>Heart/Circulation</u>	Current	History		Current	History
Congested Heart Failure	<input type="checkbox"/>	<input type="checkbox"/>	Transient Ischemic Attack	<input type="checkbox"/>	<input type="checkbox"/>
Deep Vein Thrombosis	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Lymphedema	<input type="checkbox"/>	<input type="checkbox"/>	<u>Endocrine/Metabolic</u>		
Peripheral Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes Mellitus	<input type="checkbox"/>	<input type="checkbox"/>
Coronary Artery Disease	<input type="checkbox"/>	<input type="checkbox"/>	Hyperthyroidism	<input type="checkbox"/>	<input type="checkbox"/>
<u>Musculoskeletal</u>			Hypothyroidism	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<u>Pulmonary</u>		
Osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	COPD	<input type="checkbox"/>	<input type="checkbox"/>
Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>	On Oxygen	<input type="checkbox"/>	<input type="checkbox"/>
Muscular Dystrophy	<input type="checkbox"/>	<input type="checkbox"/>	Pulmonary Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>
Missing Limb (i.e. amputation)	<input type="checkbox"/>	<input type="checkbox"/>	<u>Sensory</u>		
<u>Neurological</u>			Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>
Traumatic Brain Injury	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Alzheimer's	<input type="checkbox"/>	<input type="checkbox"/>	Cataracts	<input type="checkbox"/>	<input type="checkbox"/>
Dementia	<input type="checkbox"/>	<input type="checkbox"/>	Diabetic Neuropathy	<input type="checkbox"/>	<input type="checkbox"/>
Aphasia	<input type="checkbox"/>	<input type="checkbox"/>	Hard of Hearing	<input type="checkbox"/>	<input type="checkbox"/>
Cerebral Palsy	<input type="checkbox"/>	<input type="checkbox"/>	Deaf	<input type="checkbox"/>	<input type="checkbox"/>
Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	Legally Blind	<input type="checkbox"/>	<input type="checkbox"/>
Parkinson's Disease	<input type="checkbox"/>	<input type="checkbox"/>			

Cancer: Type: _____ Current History Type: _____ Current History

Surgeries: Yes No 1. _____ 2. _____ 3. _____

Currently on Dialysis: Yes No

Assistive devices used daily : Cane Wheelchair Walker/ Rollator Hearing Aids Other: _____

Other physical limitations: _____