Catholic Charities
Independent
Support Services

Submit by **Mail:** **Catholic Charities**
Independent Support Services
PO Box 10660
Portland, ME 04104-6060
Fax: **(207) 299-1930**
Email: **ISSReferral@ccmaine.org**

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.

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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

_____ Meal Preparation

_____Meal Planning

_____Grocery shopping

_____Banking

_____Picking up prescriptions

(Continue on back)

_____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:

Heart/Circulation	**Current**	**History**
Congested Heart Failure	□	□
Deep Vein Thrombosis	□	□
Lymphedema	□	□
Peripheral Vascular Disease	□	□
Coronary Artery Disease	□	□
Musculoskeletal		
Rheumatoid Arthritis	□	□
Osteoarthritis	□	□
Osteoporosis	□	□
Fibromyalgia	□	□
Muscular Dystrophy	□	□
Missing Limb (i.e. amputation)	□	□
Neurological		
Traumatic Brain Injury	□	□
Alzheimer's	□	□
Dementia	□	□
Aphasia	□	□
Cerebral Palsy	□	□
Multiple Sclerosis	□	□
Parkinson's Disease	□	□

	Current	**History**
Transient Ischemic Attack	□	□
Stroke	□	□
Endocrine/Metabolic		
Diabetes Mellitus	□	□
Hyperthyroidism	□	□
Hypothyroidism	□	□
Pulmonary		
Emphysema	□	□
COPD	□	□
On Oxygen	□	□
Pulmonary Vascular Disease	□	□
Sensory		
Macular Degeneration	□	□
Glaucoma	□	□
Cataracts	□	□
Diabetic Neuropathy	□	□
Hard of Hearing	□	□
Deaf	□	□
Legally Blind	□	□

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: _____

_____