Residential Living Solutions, Inc

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(320) 351-4583 ~ Office (320) 351-4584 ~ Fax

REFERRAL FORM

Date of Referral:____________________________ When is Placement Needed:____________________________

☐ Adult ☐ Teen Veteran: ☐ Yes ☐ No

Name:____ DOB:____________________ ☐ Male ☐ Female

Address:____ Zip Code:__________________ ☐ Living Alone

Telephone:________________________________(alt phone)________________________________ ☐ No Phone Available

County of residence:________________________________ Preferred city of placement:________________________________

Marital Status: ____________________________________ Prefer Family Support:____________________________________

Funding types considered/approved for this placement:

County of $ responsibility____ **GRH** Approved ☐ YES ☐ NO ☐ In Process

Private Pay ☐ YES ☐ NO Contact Info________________________________Other______________________________

Insurance Pay – Company__________________________ Phone number______________Policy #_____________________

VA Pay ☐ Possible ☐ Approved Contact name & number____

CADI Waiver ☐ Possible ☐ Approved **TBI Waiver** ☐ Possible ☐ Approved

EW Waiver ☐ Possible ☐ Approved **MA Home Care** ☐ Possible ☐ Approved

MA #_____________________________________Contact name & number____

☐ Voluntary ☐ Court Ordered ☐ Apprehension Order ☐ Other_________________________________

Reason for Referral:

☐ Assist with Mental Health Needs ☐ Court Committed ☐ Less Restrictive Setting

☐ More Restrictive Setting ☐ Needs a More Structured Plan ☐ More Individualized Approach

☐ Respite Care ☐ Wants/Needs to move out of current residence

☐ Crisis Care ☐ Other____

Primary Diagnosis:____ICD-9 #__________________________

Primary Diagnosis:____ICD-9 #__________________________

Secondary Diagnosis:____ICD-9 #__________________________

Diagnosis: Additional Information____

____

Primary Medical Diagnosis: ____

Other diagnosis (if applicable):____

____

Previous RLS Placement?	☐ YES	☐ NO	Previous Psychiatric Hospitalization?	☐ YES	☐ NO
Is there a Behavior Management Plan?	☐ YES	☐ NO	RMP Risk Management Plan?	☐ YES	☐ NO
ISP Individual Service Plan?	☐ YES	☐ NO	Crisis Prevention Plan?	☐ YES	☐ NO
Rule 40 Program?	☐ YES	☐ NO	Criminal Record/conditional release	☐ YES	☐ NO
On any Psychotropic Meds?	☐ YES	☐ NO			

If so, please list meds (just names, please)____

____

Seizure Disorder:	☐ YES	☐ NO	Allergies:	☐ YES	☐ NO

Activities of Daily Living (ADL):

Specify needs (1-reminder, 2-prompting, 3-supervision, 4-physical assistance, 5-non-needed)

________ Bathing____

________ Hygiene____

________ Dressing____

________ Eating ____

________ Walking____

Notes____

Instrumental Activities of Daily Living (IADL):

________ Financial Management ____

________ Managing Appointments ____

________ Housekeeping ____

________ Meal Prep & Cleanup____

________ Health management & maintenance____

Notes____

Health:

________ Mobility____

________ Special diet____

________ Medication administration____

Notes____

Home and Personal Safety:

________ Awake supervision____

________ Daily service checks____

________ Safety procedures & emergency responses_____________________________________

Notes____

Community Access:

________ Community access____

________ Public transportation____

Notes____

Behavior:

________ Aggressive____

________ Injury to self____

________ Severe property destruction____

________ Refusing essential health care____

Notes:____

____

How long can client be left alone: ___________________________in home ___________________________in community

Legal and Rights Issues

Limitations on legal rights include:

☐ Considered Mentally Ill and Dangerous ☐ Provisional Discharge from Psychiatric Hospital
☐ Restraining Order ☐ Felony Conviction ☐ Representative Payee
☐ Court-committed to Placement ☐ Power of Attorney ☐ Conservator/Guardian
☐ On Probation ☐ Minor ☐ Unknown
☐ None

Restrictions on: ☐ Phone ☐ Visits ☐ Activities If so, please bring list with at admission.

Education/Work Information:

Please check which program(s) client is involved in:

☐ Day Program ☐ Work Program ☐ School ☐ Other____________________

Name of School, Day program, Employer:________________________________

Contact person:____________________Phone:______________May we contact Y/N

Name of School, Day program, Employer:________________________________

Contact person:____________________Phone:______________May we contact Y/N

Case Manager

Name:______________________________Organization:____________________

Address:____

City, State Zip:________________________ Email:____________________

Phone:______________________________Alt Phone:____________________

Does RLS have permission to contact this individual about the referral? ☐ Yes ☐ No

Legal Representative

Name:______________________________Organization:____________________

Address:____

City, State Zip:________________________ Email:____________________

Phone:______________________________Alt Phone:____________________

Does RLS have permission to contact this individual about the referral? ☐ Yes ☐ No

Other Contact or Family Member

Name:______________________________Organization:____________________

Address:____

City, State Zip:________________________ Email:____________________

Phone:______________________________Alt Phone:____________________

Does RLS have permission to contact this individual about the referral? ☐ Yes ☐ No

______________________________ ____________________ __________

Signature of Person Making Referral Relationship to Referral Date

If accepted for placement we will then be requesting current ISP, BMP, Psychological Assessments, medical history, social history, etc.