



HCS / AAA Nursing Services Referral

Transforming lives

1. REFERRED TO RN PROVIDER / AGENCY / DELEGATOR: NAME		TELEPHONE NUMBER	2. DSHS OFFICE <input type="checkbox"/> HCS <input type="checkbox"/> AAA	
FAX NUMBER		EMAIL ADDRESS		DATE OF REFERRAL
3. CLIENT NAME (LAST, FIRST, MI)				
DATE OF BIRTH	TELEPHONE NUMBER	PROVIDER 1 NUMBER	ACES NUMBER	
4. CLIENT ADDRESS			CITY	STATE ZIP CODE
5. CAREGIVER NAME (LAST, FIRST, MI)		6. AGENCY NAME (IF AGENCY CAREGIVER)		TELEPHONE NUMBER
7. CONTACT NAME (IF DIFFERENT THAN CAREGIVER)				TELEPHONE NUMBER
8. CONTACT RELATIONSHIP TO CLIENT		9. GUARDIAN NAME (IF ANY)		TELEPHONE NUMBER
10. Referral Request				
10. Requested Activity (check all that apply)			11. Activity Frequency (days/week times per week / month / year)	
<input type="checkbox"/> Nursing Assessment/Reassessment (visit)			Frequency Duration of Activity:	
<input type="checkbox"/> Instruction to client and/or Providers (visit)			Frequency Duration of Activity:	
<input type="checkbox"/> Care and health resource coordination (with visit)			Frequency Duration of Activity:	
<input type="checkbox"/> Care and health resource coordination (without visit)			Frequency Duration of Activity:	
<input type="checkbox"/> Evaluation of health related elements of assessment or service plan (without visit)			Frequency Duration of Activity:	
<input type="checkbox"/> Skin Observation Protocol (with visit)			Frequency Duration of Activity:	
<input type="checkbox"/> Skin Observation Protocol (without visit)			Frequency Duration of Activity:	
12. CARE Triggered Referrals Reason for Request (Check all that apply)				
<input type="checkbox"/> Unstable/potentially unstable diagnosis		<input type="checkbox"/> Current or potential skin problem (not SOP)		
<input type="checkbox"/> Medication regimen affecting plan of care		<input type="checkbox"/> Skin Observation Protocol (SOP)		
<input type="checkbox"/> Nutritional status affecting plan of care		<input type="checkbox"/> Other reason:		
<input type="checkbox"/> Immobility issues affecting plan of care				
13. Special Instructions				
<input type="checkbox"/> Requesting visit be made with case manager		<input type="checkbox"/> Request visit with Caregiver		
<input type="checkbox"/> Consult with case manager before contacting client or caregiver		<input type="checkbox"/> Caregiver Training Requested		
<input type="checkbox"/> Additional Comments:		<input type="checkbox"/> Interpreter Required for _____ language		
14. SW / CASE / MANAGER		E-MAIL ADDRESS	FAX NUMBER	
SW / CASE / MANAGER TELEPHONE NUMBER			DATE	
IMPORTANT: Be sure to send, via fax/secure email a current CARE Assessment Details, Service Summary, Release of Information, and a copy of all of the Nursing Triggered Referrals including the Data Elements. Note: If you are serving a DDA client please use DSHS form 13-911.				
Confirmation of Receipt and Acceptance of referral by Nursing Services Provider				
<input type="checkbox"/> Referral received		Date Received:	<input type="checkbox"/> Additional Comments:	
<input type="checkbox"/> Referral accepted				
<input type="checkbox"/> Referral not accepted Reason: _____				
<input type="checkbox"/> Nurse Assigned:				
Telephone Number:				

Instructions for Completing HCS / AAA Nursing Services Referral

The Nursing Services Referral is completed for initiation of a referral to Nursing Services provided to HCS / AAA clients. This form is completed by the case manager and sent to the contracted Nursing Services provider (Area Agency on Aging, contracted agency or contracted individual RN) or the Nurse Delegator. This form should be completed each time a new referral request for nursing services is being established for a client.

1. **Referred To:** Enter the name of the Area Agency on Aging, contracted agency or contracted Nurse Consultant, Registered Nurse Delegator telephone number, fax number, and email address.
2. **DSHS Office:** Enter the name of the HCS / AAA office.
3. **Client Name:** Enter the client's name, date of birth, telephone number, Provider 1 number and ACES ID number.
4. **Client Address:** Enter the address where the client is residing, and would receive services.
5. **Caregiver Name:** Enter the caregiver name. If the client has multiple caregivers, enter the name of the primary caregiver for the client. Enter the telephone number of the caregiver.
6. **Agency Name:** Enter the name of the Home Care Agency as needed. Enter the telephone number of the Home Care Agency.
7. **Contact Name:** Enter any contact name information if different than the caregiver.
8. **Contact Relationship to Client:** Enter the relationship of the contact name to the client (e.g. parent, sibling, friend).
9. **Guardian Name and Telephone Number:** Enter the guardian name and telephone number as appropriate.
10. **Referral Request:** The case manager checks all of the nursing services requested for the client, indicating the type of activity and whether a visit is requested with that activity. (ADSA Chapter 24 LTC Manual).
11. **Requested Activity Frequency:** Enter the frequency and duration of the activity requested (e.g. once a month for six months, once a week for two weeks, one time only).
12. **Reason for Request:** Enter the CARE Triggered Nursing Referral Indicator(s) or other reason the client is being referred for Nursing Services.
13. **Special Instructions:** Enter any special instructions for this Nursing Services referral. This includes contacts to be made prior to the activity, whether a joint home visit needs to be made, and any other additional comments.
14. **SW/Case Resource Manager:** The referrer completes this information with the case manager name and contact information.

Confirmation of Receipt and Acceptance of Referral by Nursing Services Provider

The receiving Nursing Services provider completes the section to indicate to the referral source the receipt and acceptance of the referral to provide the requested nursing activity. The referral form is sent back to the referral source with the following information completed within two working days.

Referral Received: Enter the date the referral was received.

Referral Accepted: Check this box if the referral is accepted and the provider is able to provide the requested nursing services activities.

Referral Not Accepted: Check this box if the referral is not able to be accepted, and the provider is unable to provide the requested activities.

Nurse Assigned: Enter the name of the nurse and contact information (telephone, office and e-mail as needed).

Additional Comments: The Provider enters any additional comments needed for the referent.