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|  | HOME AND COMMUNITY SERVICES (HCS)  **Adult Day Service Referral** | | | 1. REFERRAL TO: | | | |
| 2. REFERRED FROM:  HCS  AAA | | | 3. DATE OF REFERRAL |
| All fields are required unless “optional” is indicated in the field. | | | | 4. PROVIDER AUTHORIZATION NUMBER | | | |
| 5. CLIENT’S NAME (LAST, FIRST, MIDDLE INITITAL) | | | | 6. DATE OF BIRTH | | 7. PHONE NUMBER (AND AREA CODE)  **(     )** | |
| 8. ACES ID NUMBER | | 9. CLIENT’S ADDRESS: STREET CITY STATE ZIP CODE | | | | | |
| 10. PRIMARY CAREGIVER’S NAME OR AGENCY NAME | | | | | | 11. PHONE NUMBER OF AGENCY  **(     )** | |
| 12. REFERRED PROGRAM  Adult Day Care  Adult Day Health  To be determined at the center | | | | | | | |
| 13. REASON FOR REFERRAL  Unstable / potentially unstable diagnosis  Client has one or more of the following diagnoses (check all that apply):  Diabetes  CHF  COPD  Recurrent UTI’s  Edema  Dementia  Obesity  Stroke  ALS  Parkinson’s  TBI  MS  Other:  Medication regimen affecting plan of care  Mobility issues affect plan of care  Client has one or more of the following conditions (check all that apply):  Poor balance  Poor transfers  Fall history  Deconditioning  Unsteady gait  Poor hand / eye coordination  Limited ROM  Uses wheelchair  Uses walker  Uses cane  Current or potential skin problem  Nutritional status affecting plan of care  Other: | | | | | | | |
| 14. REQUESTED ACTIVITY (CHECK ALL THAT APPLY)  Nursing Assessment  OT Assessment  PT Assessment  Speech Assessment  Audiology Assessment  Social Work consult  Rehab Assessment  Other: | | | | | | | |
| 15. ADDITIONAL INFORMATION | | | | | | | |
| 16. REFERRING CASE MANAGER’S NAME | | | | | TITLE | | |
| PHONE NUMBER (AND AREA CODE)  **(     )** | | | FAX NUMBER (AND AREA CODE)  **(     )** | | EMAIL ADDRESS | | |
| **IMPORTANT: Please be sure to fax or email current CARE Assessment with referral** | | | | | | | |
| **Confirmation of Acceptance** | | | | | | | |
| Referral received; date received:  Referral accepted  Referral not accepted; reason(s): | | | | | | | |

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| **Adult Day Service Referral Instructions**  **All fields are required unless “optional” is indicated in the field.**   1. Referral To: Enter the adult day centers name. 2. Referred From: Identify what office the referral is being sent from. 3. Date of Referral: Enter date referral was sent to adult day center. 4. Provider Authorization Number: Enter approved adult day center authorization number. 5. Client’s Name: Enter client’s full name (last, first, and MI). 6. Date of Birth: Enter client’s date of birth (month, day, and year). 7. Telephone Number: Enter client’s telephone number, include area code. 8. ACES ID: Enter clients ACES ID. 9. Client’s Address: Enter client’s physical address (house address, city, state, zip code). 10. Primary Caregiver’s Name or Agency Name: Enter the name or agency name of client’s primary caregiver. 11. Telephone number of Agency: If an agency is the client’s primary caregiver, list the agency phone number, include area code. 12. Referral Program: Identify which program the client’s is being referred to. If unable to determine, check “to be determined at the center.” 13. Reason for Referral: Identify why the client is being referred to adult day services. If reason is not identified on the referral form, indicate why under “other”. 14. Requested Activity: Identify what activity the client is being referred for. If reason is not identified on the referral form, indicate what activity under “other”. 15. Additional Information: Enter additional information which is pertinent to the clients care or useful for the adult day center to know. 16. Referring Case Manager’s Name / Title, Phone, Fax number, and Email address: Enter the name and title of the referring case manager with contact information (telephone, fax, and email address).   Confirmation of Acceptance: The adult day center will respond to the referral within two business days, acknowledging receipt of referral as illustrated by a date and response. |