Adult Services Referral Form

Client Name:	Date of Birth:
Funding? Medicaid B: Medicaid B (3): Medicaid B (3) "Additional Services": Medicaid C (Innovations Waiver): Alliance TBI Waiver: Workers' Compensation: MCO TBI Funds: State Funds: Other:	County of Medicaid:
Social Security #:	MCO ID #:
Address:	Home #: Mobile #:
Client Entitlements (SSI, SSDI, etc.)	Residing County
Does this person have a legal guardian? If so, who?	Does this person have a representative payee? If so, who?
Primary language spoken in home:	Housing status (type and who do they live with):
Referring Staff Name and Agency:	Referring Agency phone #: Fax #:

Medical History

Please provide as much information regarding psychiatric and medical history as possible

Current psychiatric care provider: Dr. _____ Clinic/Practice name and address:	Current primary care provider: Dr. _____ Clinic/Practice name and address:

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Psychiatric diagnoses (include DSM-V codes): Physical Limitations or needs:	Current/recurrent medical diagnoses: Any additional information:

Psychiatric Provider History

Please provide as much information as possible

Is the client currently using any outpatient services? ☐ Yes ☐ No If *Yes*, please provide details:

Name of Service:

Contact name:	Telephone #

Is the client currently in a hospital? ☐ Yes ☐ No

Has the client had any psychiatric and or medical hospitalizations in the last 5 years? ☐ Yes ☐ No

Date admitted:		Facility/outpatient service:
Date discharged:		
Date admitted:		Facility/outpatient service:
Date discharged:		
Date admitted:		Facility/outpatient service:
Date discharged:		

Current Medications

Pharmacy name:	Telephone #

What activities of daily living is client able to do?

Why does client need services at this time?

LUTHERAN SERVICES CAROLINAS

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Independent Living Skills

Indicate the level of assistance needed by marking an X under the correct heading

ACTIVITY	1. I CAN DO MYSELF	2. I NEED TO BE REMINDED	3. I NEED HELP
TOILETING			
LAUNDRY			
TAKING MEDICATIONS			
DRESSING			
LEISURE ACTIVITIES			
MANAGE MY MONEY			
TRANSPORTATION			
HOUSEHOLD CHORES			
GROOMING			
GROCERY SHOPPING			
SIMPLE MEAL PREP			
BATHING			
JOB/DAILY ACTIVITIES			
EATING/DRINKING			
OTHER			

If other, please explain: _____

_____

Is there anything else we need to know? _____

_____

_____

Please attach the following documentation for this referral:

- CCA or admission assessment
- Discharge summary(s)
- Physician's order/medication history sheet
- Most recent PCP/ISP
- Most recent psychiatric evaluation or neuropsychiatric evaluation
- 6 most recent service notes

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Employment and Volunteer History

Have you ever worked? Yes_____ No_____ Do you have any interest in working? Yes_____ No_____

If yes, please complete the following information:

Place of Employment	Date/Length	Hours/Week	Reason for Leaving
Job Duties:			

Place of Employment	Date/Length	Hours/Week	Reason for Leaving
Job Duties:			

Place of Employment	Date/Length	Hours/Week	Reason for Leaving
Job Duties:			