Referral worksheet

Service requested: ☐ Guardianship ☐ Emergency/Temporary guardianship

Personal information or person being referred

Exact full name	Date of referral
Date of birth	Marital status
Social Security #	VA #
Medicaid #	Medical insurance

Current location of individual

Please indicate the individual's current, immediate location.

☐ Facility ☐ Hospital ☐ Own home (If in own home, do they ☐ own or ☐ rent?)

Facility or hospital name (if applicable)

Street address	Room #	City	State	Zip
Phone	Alt. phone, fax, cell, email (specify)			
Expected date of discharge (if any)	Name and number of contact person			

Permanent or regular residence

Please indicate where the individual regularly resides, if different from above.

Facility name (if applicable)

Street address	Room #	City	State	Zip
Phone	Alt. phone, fax, cell, email (specify)			
Dates	Notes Re: this location			

Referral source contact information

Please supply your name and contact information.

Name, title	Agency, office, or hospital name			
Street address	Room #	City	State	Zip
Phone	Alt. phone, fax, cell, email (specify)			

Medical providers

Medical and mental health professionals who have treated or evaluated:

Name, title	Office or hospital name			
Street address	Room #	City	State	Zip
Phone	Alt. phone, fax, cell, email (specify)			

Name, title	Office or hospital name			
Street address	Room #	City	State	Zip
Phone	Alt. phone, fax, cell, email (specify)			

Contacts

Persons having direct knowledge of the incapacities outlined above (Case manager, social worker, nurse, physician, family, others)

Name, title	Agency, office, or hospital name			
Street address	Room #	City	State	Zip
Phone	Alt. phone, fax, cell,e-mail (specify)			

Name, title	Agency, office, or hospital name			
Street address	Room #	City	State	Zip
Phone	Alt. phone, fax, cell, email (specify)			

Name, title	Agency, office, or hospital name			
Street address	Room #	City	State	Zip

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Phone	Alt. phone, fax, cell, email (specify)

Supports (Spouse, parents, adult children, co-habitants, nearest relatives, attorneys.) **Include all, even uninvolved.**

Name	Relationship			
Street address	Room #	City	State	Zip
Phone	Alt. phone, fax, cell, email (specify)			

Name	Relationship			
Street address	Room #	City	State	Zip
Phone	Alt. phone, fax, cell, email (specify)			

Name	Relationship			
Street address	Room #	City	State	Zip
Phone	Alt. phone, fax, cell, email (specify)			

Name	Relationship			
Street address	Room #	City	State	Zip
Phone	Alt. phone, fax, cell, email (specify)			

For this referral to be considered, please attach the following information:

Psychological/Psychiatric evaluation	**No**	**Yes**	**(Attach copy)**
Physician letter	**No**	**Yes**	**(Attach copy)**
Medical history & physical	**No**	**Yes**	**(Attach copy)**

Guardianship/criteria narrative

1. Please provide us with a written description of what you expect a guardian to do. Items you may want to include in this narrative are:

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a. Does this person adequately provide for their healthcare?
b. Does this person adequately provide for their food, nutrition and shelter?
c. Does this person adequately provide for their clothing or personal hygiene?
d. Does this person adequately provide for their safety and/or other care, without which serious injury is likely to occur?
e. Is this person able to manage their financial resources?
f. Has there been APS involvement with this person?
g. Other relevant information

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