AGING AND DISABILITY RESOURCE CENTER AGENCY REFERRAL FORM

Aging and Disability Resource Center - Ph: 961-8626 - Fax: 961-8603 - adrc-ianda@hcoahawaii.org

SECTION I – REFERRAL SOURCE		
Date of Intake:	Time of Intake:	☐ APS
Agency Name:	Person Completing Form:	
Agency E-mail:	Phone: Fax:	
Planned Discharge Date (if applicable):	Client's Current Location: ☐ Home/Community ☐ Other:	

SECTION II – CONSUMER PROFILE * * * This section is REQUIRED * * *			
Contact Type: ☐ Home Visit ☐ In-Office Visit ☐ Telephone ☐ Other (Please describe):			
LAST NAME:	FIRST NAME:	M.I.:	A.K.A.
Mailing Address:	City:	State:	ZIP:
Physical Address:	City:	State:	ZIP:
Phone Number:	Alternate Phone Number:	Date of Birth:	
Gender: ☐ M ☐ F ☐ Other: ☐ Prefer not to disclose			
Marital Status: ☐ Married ☐ Divorced ☐ Widowed ☐ Never Married			
☐ U.S. Citizen ☐ Legal Resident Alien ☐ Other: ☐ U.S. Veteran ☐ Consumer lives alone			
CAREGIVER INFORMATION (if applicable)			
Last Name:	First Name:	Relationship to Consumer:	
Mailing Address:	City:	State:	ZIP:
Physical Address:	City:	State:	ZIP:
Phone Number:	Alternate Phone Number:	Date of Birth:	

SECTION III – MEDICAL AND FINANCIAL INFORMATION			
Diagnoses & Medical Concerns:			
Physical & Cognitive Conditions:			
Primary Care Physician:	Health Clinic (if applicable):		
Medical Insurance: ☐ Medicare ☐ Medicaid ☐ None ☐ Other:			
Monthly Household Income: $	Source(s) of Income:	Assets: ☐ < $2,000 (single) ☐ < $3,000 (couple)	
☐ Power of Attorney (POA)	Name:	Relationship to Client:	Phone:
☐ Advance Health Care Directive (Agent)	Name:	Relationship to Client:	Phone:
ADLS (check if deficiency): ☐ Eating ☐ Dressing ☐ Bathing ☐ Toileting ☐ Transferring ☐ Walking			
IADLS (check if deficiency): ☐ Meal Prep. ☐ Shopping ☐ Med. Mgmt. ☐ Telephone ☐ Chore ☐ Homemaker ☐ Trans.			
Consumer Risk Factors:			

SECTION IV – INTAKE SUMMARY AND REFERRAL
Summary of Client Needs: *Please describe client's needs (e.g. functional (ADL/IADL), environmental, social, etc.)* * * * *REQUIRED* * * *
Caregiver Needs (if applicable): *Please describe caregiver needs.*
Additional Notes (optional) *Share any other information pertinent to the client/caregiver's situation.*

SECTION V – CONSUMER AUTHORIZATION TO SUBMIT REFERRAL * * * This section is REQUIRED * * *		
Client AUTHORIZES referral (check one) ☐ Yes ☐ No Client Signature: _____ Date: _____		
If Yes, but client is unable to sign: Authorized Representative's Signature: _____ Date: _____		
Authorized Representative's Name:	Representative's Relationship to Client:	
☐ Check here if client has given verbal consent authorizing this referral.		
Person to Contact Regarding Referral & Services		
☐ Consumer (self)	☐ Other: Name:	Phone:

SECTION VI – ADRC ACTION * * * FOR ADRC USE ONLY * * *			
Action Taken	Date	Staff Initials	Notes
Referral Received by the ADRC			☐ Fax ☐ E-mail ☐ Hand-Delivered
Referral Received by ADRC & forwarded to I&A Clerk			
Referral entered in Call Log and forwarded to ADS			