**ADRC CLIENT REFERRAL FORM**

Please send completed form, along with supporting documents, to:

Email: ADRCreferrals@lacrossecounty.org OR Fax: 608-785-5790

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| **Referral Agency:** |       | **Referral Person:** |       |
| **Phone Number:** |       | **Date:** |       |
| **Has verbal/written consent been obtained for this referral?** | [ ]  Yes [ ]  No |
|  **If yes, date of consent:** |       | **Inpatient?** | [ ]  Yes [ ]  No |
| **Anticipated discharge date:** |       | **D/C to SNF?**  | [ ]  Yes [ ]  NoWhere:       |
| **Referral to Elevate for MA?**  | [ ]  Yes [ ]  No | \*\*A referral to Elevate may streamline access to Medical Assistance (MA)  |
| * **Please attach a completed authorization/release of information if applicable.**
* ***If client/patient is requesting Family Care/IRIS/long-term care functional screen, please attach current problem list/diagnosis list.***
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| **Client/Patient Name:** |       | **Address:** |       |
| **DOB:** |       | **City, State, Zip:** |       |
| **Phone Number:** |       | **Gender:** |       |
| **Race/Ethnicity (optional):** |       |  |  |
| **Email (optional):** |       |

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| ***Contact Person/Legal Decision Maker (i.e., Legal Guardian, Activated POA) Information:*** |
| **Name:** |       | **Phone:** |       |
| **Relationship:** |       | **Address:** |       |
| **Date of Health Care POA Activation:** |       | **City, State, Zip:** |       |

**Reason for Referral:**

**[ ]  Dementia Care Planning Consult** **[ ]  Home-delivered Meals** **[ ]  Other (describe below)**

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**Primary Diagnoses/Problem List:**

***(\*If requesting a functional screen, please attach a full list of current diagnoses.)***

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**Additional Comments:**

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