**A picture containing company name

Description automatically generatedADRC 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  No  Where: |
| **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.*** | | | | | |
| **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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