

Department of Health and Human Services
Adult Mental Retardation Services
Referral

Date of Referral _____

Services Requested:

- Day Hab Transportation Other
 Employment Respite
 Residential Services Case Management

Reason for Referral: _____

Name of Applicant _____ Male Female

Address: _____

Mailing Address: _____

Telephone #: _____ DOB: _____

Social Security #: _____ Social Security Disability yes no
Medicaid #: _____ SSA yes no
Medicare#: _____ SSI yes no
Rep. Payee yes no

Referred by:

Community Caseworker Date _____ DHHS Caseworker Date _____

Name: _____

Address: _____

Phone #: _____

Approved by: Legal Guardian
 Self

Name: _____

Address: _____

Phone #: _____

Name of Emergency Notification: _____

Address: _____

Phone #: _____

Referral Packet (Please check all information included)

- | | | |
|--|---|--|
| <input type="checkbox"/> Medical Assessment | <input type="checkbox"/> P.T Assessment | <input type="checkbox"/> Behavioral Assessment |
| <input type="checkbox"/> Psychological Assessment | <input type="checkbox"/> Speech/Language Assessment | <input type="checkbox"/> OT Assessment |
| <input type="checkbox"/> Annual Plan | <input type="checkbox"/> PET/Academic Records | <input type="checkbox"/> Dental |
| <input type="checkbox"/> Psychiatric Evaluation/Med Review | <input type="checkbox"/> Counseling Reports | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Releases attached | | |

Diagnosis/Disability

Primary _____ Secondary _____

