



CONSUMER REFERRAL FORM

Client's Name: _____

Social Worker _____

Phone Number: _____

Email address: _____

Date: _____

PRIORITY: High/ Med / Low

HIRING AND SUPERVISION: Self Other

Name: _____ Relationship: _____ Ph # _____

Name: _____ Relationship: _____ Ph # _____

Does the client need assistance interviewing? Yes No Is there a share of cost? _____

What is the client's experience/understands how to:

Enroll providers in IHSS? First time/ inexperienced some experience no help or training needed

Manage time sheets First time/ inexperienced some experience no help or training needed

Share of cost issues First time/ inexperienced some experience no help or training needed

New provider: Number of hours: _____ hrs/ monthly = _____ hrs/ weekly

Client's Cognitive functions and ability to train and supervise: High/Independent Med Low

DRIVING:

Family friend will assist with driving

Client relies on Whistlestop or other transportation method most of the times

Client needs provider to drive to all appointments, or other needs including shopping

AMBULATION:

No assistance needed Cane Walker Wheelchair Bed bound

CARE & ASSISTANCE WITH PROSTHESIS:

Assistance w/ prosthesis Specify: _____

Assistance with medication Specify: _____

Assistance with Hoyer lift Specify: _____

Comments:

Senior / Disabilities: _____

Pets: Y/ N _____

Circle Selection: Female / Male Transportation: Y / N Live Alone: Y/ N Smoker: Y/ N

Days Desired: Monday Tuesday Wednesday Thursday Friday Saturday Sunday

Start Time: _____ AM _____ AM _____ AM _____ AM _____ AM _____ AM _____ AM

End Time: _____ PM _____ PM _____ PM _____ PM _____ PM _____ PM _____ PM