Document #103
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Approved by: T. Holmes

******* SVRC REFERRAL APPLICATION *******

PLEASE COMPLETE FORM. IF NOT FULLY COMPLETED, WITH REQUIRED REPORTS AND COPIES ATTACHED, INTAKE WILL BE DELAYED.

1. Name ____ 2. SS# _____________________________

3. Street ________________________________ City ____________________ State _____ Zip Code _______

4. Telephone ____ 5. Date of Birth _______________________

6. Living Arrangement: Parent(s) _____ Guardian _____ Group Home _____ Independent _____

7. Is individual his/her own legal guardian? Yes ___ No ___ (If no, complete a – f)

   a. Legal Guardian's Name ____

   b. Relationship to Individual __________________________ c. Telephone _________________________

   d. Street ____________________________ City ____________________ State _____ Zip Code ______

   e. Type of Guardianship ____

   f. Emergency Contact Person __________________________________ Telephone ____________________

8. Financial Resources: SSI $_____ SS $_____ AFC $_____ SDI $_____ Include copy of Medicaid card

9. Medical Information:

   a. Date of last physical exam ____________ (Attach copy–should be less than 1 year old, if possible)

   b. List all known allergies ____

   c. Hepatitis Status ____ Last testing date _______________

   d. Current Medications: Name (including milligrams) Amount Frequency (exact times, i.e., 8:30 a.m.)

Name (including milligrams)	Amount	Frequency (exact times, i.e., 8:30 a.m.)
______________________________	__________	________________________________
______________________________	__________	________________________________
______________________________	__________	________________________________

   e. Does individual wear: Glasses – yes ___ no ___ Hearing Aid – yes ___ no___

   f. Does individual use adaptive equipment: yes ___ no ___ If yes, describe equipment and use (include wheelchairs, helmets, etc.)

   g. Describe medical problems, physical disabilities and physical limitations (include sensitivity to drafts, restrictions or activities, etc.)

   h. Special dietary restrictions

   i. Doctor's name, address and telephone

10. Evaluations:

    a. Referring Diagnosis: Primary __________________________ Secondary ____________________________

    b. Date of last psychological eval (if applicable) ________ Attach other evaluations done in the past 12 months

11. Education:

    a. Special Education: yes ___ no ___ If yes, number of years _____

    b. Graduated: yes ___ no ___ High School: yes ___ no ___ Special Education: yes ___ no ___

12. Transportation:

    a. Own transportation: yes ___ no ___

    b. Group home: yes ___ no ___

    c. Public transit: yes ___ no ___

    d. Other _______________________________

13. Describe client's special interests/hobbies/preferences (include information on known reinforcers)

14. Describe abilities and strengths

15. Describe known inappropriate behaviors (self-abuse, etc.) and how they are handled

16. Possible areas of need or improvement

17. State in specific terms your suggestions for this client's service plan at SVRC (ADL, motor, social, etc.)

Referral Contact Person _____________________________________ Title ____________________________________

Agency ____ Telephone ______________________________

Street _____________________________________ City ___________________ State _____ Zip Code __________

Date __________________________

PLEASE NOTE: LEGIBLE COPIES OF THE FOLLOWING ARE REQUIRED:

Physical examination _____

Psychological evaluation _____

Medicaid and Medicare cards if CMH _____

Face sheet if CMH _____