

Community Services Referral Summary
Fax to UDS: (717) 293-1595

Date of Referral: _____

Determine purpose of call.

Referral Source (Person Making Initial Call)

Name	
Agency	
Address	
Tel.	
Fax	

Consumer

Name	
Residential Address	
Tel.	
SS#	
D.O.B.	
Gender	

Contact Information

Primary Contact Friend/Family	
Relationship	
Address	
Tel.	

Is consumer alert and oriented? (Circle) Yes No

If No: Legal Guardian /POA Name: _____ Tel.: _____

Who has been made aware of this referral? (Circle) Consumer Family/Friend

Who should be contacted to arrange assessment? _____

Does consumer live alone? (Circle) Yes No

Triage Questions:

If you, (or the person you are calling for), does not receive home and community based services soon, will you, (or the person you are calling for) have to go to a nursing home? If yes then A., if no then B.

A. Which nursing home, _____. When do you, (or the person you are calling for) plan to go to a nursing home? Date: _____.

B. When do you, (or the person you are calling for) need services to start? Date: _____.

Medical History

Diagnoses		Is this person a possible amended OBRA Target?	Yes	No
		Age of onset? (Under22 to Qualify for OBRA)		
Physician				
Physician Tel.#				

Which of the following activities do you need assistance with? (Check Yes or No)

- Dressing Yes No
- Bathing Yes No
- Grooming Yes No
- Toileting Yes No
- Meal Preparation Yes No
- Are you in need of Respite Services? Yes No

Does the consumer receive formal services at this time? (Check Yes or No)

- MR Yes No
- MH Yes No
- OVR Yes No
- Office of Aging Yes No

Determining Financial Eligibility:

Does consumer have MA? Yes No

Form completed by: _____