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ADAPTA REFERRAL FORM

****completion of this form does not guarantee placement****

A) Service Recipient Info

Name: _____ DOB: _____

Gender: Male Female

Current Location: _____

Address: _____ Phone: _____

Service Recipient CELL Number: _____

Location Contact: _____ Phone: _____

When are services needed: _____

Guardian: Yes (if "Yes" please fill information below) No

Name: _____ Phone: _____

B) Referral Source

Name: _____ County: _____ Date: _____

Phone: _____ Email: _____

C) Financial Information

Waiver in place: Yes No If Yes, which county: _____

GRH Recipient: Yes No

Requires financial assistance: Yes No

Assistance in paying rent Yes No

Assistance and/or support with personal needs budgeting Yes No

Adapta offers limited rep-payee services and/or a Resident Trust Account services (RTA). RTA accounts require a deposit at admission.

MA number: _____ PMI number: _____

SS#: _____ Medicare #: _____

D) General Contact Information

Contact	Name, Address, Telephone, & Email
Legal representative:	
Authorized representative:	
Representative Payee:	
Primary emergency contact:	
Case manager:	
Family member:	
Family member:	
Probation:	
Financial worker:	
Vocational contact:	

E) Health Care Information

• *Medical Information*

Primary Medical Diagnoses: _____

Allergies: _____ Medical Equipment: _____ Protocols: _____

Specialized Dietary Needs: _____ Personal Care Needs: _____

- *Brain Injury* Yes No

If yes, type and date of injury: _____

- *Substance Use Disorder* Yes No

If yes, Drug(s) of choice: _____ Length of Sobriety: _____

Past Treatment: _____ Current relapse prevention plan: _____

- *Mental Health Condition(s)* Yes No

If yes, Diagnoses: _____ Past Hospitalizations: _____

Psychiatrist: _____ Therapist: _____

Other team members (ARMHS, etc): _____

Primary Medications: _____

F) Health-related Contact Information

Contact	Name, Address, Telephone, & Email
Primary health care professional:	
Psychiatrist:	
Other mental health professional:	
Neurologist:	
Dentist:	
Optometrist/Ophthalmologist:	
Audiologist:	
Pharmacy:	
Hospital of preference:	
Other health professional:	
Other health professional:	

Has this person ever been seen at a Mayo Clinic facility? Yes No If yes, Mayo Clinic #: _____

G) Presenting and/or Past Challenges

- | | | |
|---|--|---|
| <input type="checkbox"/> Elopement Risk | <input type="checkbox"/> Suicidal tendencies | <input type="checkbox"/> Mental Health Management |
| <input type="checkbox"/> Sexually active | <input type="checkbox"/> Physically aggressive | <input type="checkbox"/> Memory Loss |
| <input type="checkbox"/> Sexually inappropriate | <input type="checkbox"/> Verbally aggressive | <input type="checkbox"/> Anger/Frustration |
| <input type="checkbox"/> Fire setting | <input type="checkbox"/> Destructive to Property | <input type="checkbox"/> Money Management |
| <input type="checkbox"/> Cruelty to animals | <input type="checkbox"/> Drug/Alcohol seeking | <input type="checkbox"/> Communication |
| <input type="checkbox"/> Gang Affiliation | <input type="checkbox"/> Hygiene concerns | <input type="checkbox"/> Poor Judgement |
| <input type="checkbox"/> Smoking | <input type="checkbox"/> Frequent placements | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Theft/Stealing | <input type="checkbox"/> Isolates | <input type="checkbox"/> Other |
| <input type="checkbox"/> Hoarding | <input type="checkbox"/> Impulsive | |

Adapta to Complete this Section Below

RN Assessment Completed

Yes

Date: _____

Location: _____

Staff: _____

No

Reason: _____

Documentation needed upon admission (when applicable):

- Most recent history and physical
- Current Medication Administration Record – MAR and/or TAR
- Guardianship Papers
- Probation requirements
- Standing Orders signed
- Prescriptions sent to Hunt Pharmacy (copies sent to Adapta)

- Advanced Directive/POLST/Healthcare POA
- Previous placement treatment plans/IAPP
- (-) UA
- CAF Form
- CSSP
- Diagnostic Assessment
- Social Security amount (if applicable)
- Housing Support amount (if applicable)
- Power of Attorney paperwork/POA

Anticipated Health Care Service's Needs:

- Medication Management Describe: _____
- Medication Administration Describe: _____
- Treatment/Therapy Management Describe: _____
- Treatment Administration Describe: _____

Are there any upcoming or follow-up appointments?

Where: _____ Date: _____ Time: _____

Where: _____ Date: _____ Time: _____

Other Health Care Needs:

Describe: _____

