

CLS/Respite Service Referral Form

Date of Referral: Click or tap here to enter text. Case Manager/Therapist: Click or tap here to enter text.

Consumer Name: Click or tap here to enter text. Case Manager Phone #: Click or tap here to enter text.

County/Organization: Click or tap here to enter text. Case Manager Email: Click or tap here to enter text.

Case#: Click or tap here to enter text. Agency: Click or tap here to enter text.

Category: I/DD SED SED Waiver

DOB: Click or tap here to enter text. Male Female

Primary Address: Click or tap here to enter text.

Diagnosis: Click or tap here to enter text. Diagnosis / ICD Code: Click or tap here to enter text.

**Services Requested:**

CLS  Respite (Hourly or Overnight) Hourly. Mileage

Hours of service(s) authorized: Respite: Click or tap here to enter text. CLS: Click or tap here to enter text.

Has family identified staff they want to provide services?  Yes No.

Referred staff contact: Name: Click or tap here to enter text. Phone: Click or tap here to enter text.

Areas of Focus (as related to IPOS): Click or tap here to enter text.

Transportation into the community: Required Not Required  Strongly Preferred

Communication Methods: Click or tap here to enter text.

Any noted Behavioral Issues: Click or tap here to enter text.

Home environment:  Smoking Non-smoking Pets: No pets  Pets Click or tap here to enter text.

**Family Contact Information:**

Guardian? Self  Parent/Step-Parent  Other 🡨Specify: Click or tap here to enter text.

Parent/Guardian Name: Click or tap here to enter text.

Phone Number: (H) .(C) Click or tap here to enter text.

Parent/Guardian Email: Click or tap here to enter text.

Emergency Contact: Name: Click or tap here to enter text. Phone: Click or tap here to enter text.