 **ADRC CLIENT REFERRAL FORM**

**Please send completed form, along with supporting documents, to:**

Email: **ADRCJC@co.jackson.wi.us OR fax to 715-284-7713**

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| **Referral Agency:** |       | **Referral Person:** |       |
| **Phone Number:** |       | **Date:** | Click or tap to enter a date. |
|  **Is client/patient aware a referral is being made to the ADRC?**  | [ ]  Yes [ ]  No |
| **Has verbal/written consent been obtained for this referral?** | [ ]  Yes [ ]  No |
|  **If yes, date of consent:** |       |  |  |
| * **Please attach a completed authorization/release of information if applicable.**
* **If client/patient is requesting a long-term care functional screen, please attached current problem list/diagnosis list.**
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| **Client/Patient Name:** |       | **Address:** |       |
| **DOB:** |       | **City, State, Zip:** | Choose an item. |
| **Phone Number:** |       | **Gender:** | Choose an item. |
| **Race/Ethnicity (optional):** |       |  |  |
| **Email (optional):** |       |

 **Lives Alone?** [ ]  Yes [ ]  No **In Poverty?** [ ]  Yes [ ]  No

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| ***Contact Person/Legal Decision Maker (i.e., Legal Guardian, Activated POA) Information:*** |
| **Name:** |       | **Phone:** |       |
| **Relationship:** |       | **Address:** |       |
| **Date of Health Care POA Activation:** |       | **City, State, Zip:** |       |

**Reason for Referral:**

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|       |

**Additional Comments:**

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