Diagram

Description automatically generated with low confidence **ADRC CLIENT REFERRAL FORM**

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

Email: **[ADRCJC@co.jackson.wi.us](mailto:ADRCJC@co.jackson.wi.us) OR fax to 715-284-7713**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **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.** | | | | | |
| **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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| ***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:**

|  |
| --- |
|  |

**Additional Comments:**

|  |
| --- |
|  |