ADRC CLIENT REFERRAL FORM

Please send completed form, along with supporting documents, to:
Email: ADRCJC@JacksonCountywi.gov **OR fax to 715-284-7713**

Referral Agency: _____ **Referral Person:** _____

Phone Number: _____ **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:** _____

Phone Number: _____ **Gender:** _____

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:
