

AHL HealthCare Group, Inc. At Home Living Facilities, At Home Living Facilities Metro, BRIDGES to Success, Wesley Residence of Duluth, Garden Terrace

Phone: 218-728-1189 Fax: 218-722-2325

Referral Form/Initial Intake Screening

Service options in Duluth area include: Community Residential Settings (CRS), Intensive Residential Treatment Services (IRTS), Assisted Living, Community/Unit-based Services PO Box 16510 Duluth, MN 55816 Fax: 218-722-2325 Phone: 218-728-1189

Service options in Metra area include: Community Residential Settings (CRS), Day Support Services, Community/Unit-based Services

1200 Osborne Rd Fridley, MN 55432 Fax: 763-786-4365 Phone: 763-786-5789

You can also visit our website at: www.ahlhealthcaregroup.com

Demographic Information Location:

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Referral Name:	Would like services by:			
Person making referral and preferred contact info:				
Referral Phone:	Referral email:			
Referral current address:				
Seeking what services: ☐ Community Residential Setting (AFC/CRS) ☐ Assisted Living				
☐ IRTS ☐ Community/uni	☐ IRTS ☐ Community/unit-based ☐ Day Support Services			
Reason for referral:				
Where did you hear about our services?				
DOB:	SSN:			
Legal Status: □ voluntary □ committed	Cultural/Spiritual considerations:			
MA #:	Medicare #:			
Funding Source:	Co. of financial responsibility:			
Current symptoms and severity:				
Primary diagnosis:	Primary diagnosis code:			
Other diagnosis:				

Contacts

Case Manager:	Name: Address: Phone: Fax: Email:
Guardian:	Name: Address: Phone: Fax: Email:
Other (ie social worker, ARMHS worker, primary care physician, Psychiatrist, therapist, emergency contact, probation officer, etc): Attach list if necessary	

Expectations of staff (What services do you want to see us provide/what is the goal for placement, etc.)

Social History	
(ie: family history, previous placements, employment history, support systems, etc.)	
Psychosocial Status	
(ie. Awareness level, personal care needs, need for privacy or socialization)	
Medical/Personal Hygiene Needs	
(ie. diabetes mgmt, dietary needs, hx communicable disease, incontinence, need for privacy, advance directive, upcoming appointments, etc.)	
Please attach a current prescription and OTC medication list including what is currently being taken.	
Functional Status (ie. Endurance and capability for ambulation, transfer, and managing activities for daily living)	
Strengths and Effective Strategies (ie. What has worked in the past, what	
do you pride yourself in, etc.)	
Vulnerabilities /Risk	
Management (ie. Communication, abuse, financial, safety, housing, mobility)	
Behavioral Summary	
(ie. SIB, aggression, property destruction, elopement, drug/alcohol use, sexual behavior, triggers, etc.)	

Physical Status (Based on observation)		
Supervision Expectations	☐ Can come and go from home/day center a ☐ Can leave unsupervised for up to hou ☐ Must have staff available to them at all ti Notes:	ars at a time
Safety Check Expectations (Indicate SI/HI/SIB ideation, plan, intent)	hours and every min/hrs during sleep hours	
Additional Inforn	nation (Include any information you feel is important f	for us to know about this individual)
Signature of individu	al making the referral	Self/Title/Licensure
	idual making the referral	Date