



**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.)

<p><b>Social History</b> (ie: family history, previous placements, employment history, support systems, etc.)</p>	
<p><b>Psychosocial Status</b> (ie. Awareness level, personal care needs, need for privacy or socialization)</p>	
<p><b>Medical/Personal Hygiene Needs</b>  (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.</p>	
<p><b>Functional Status</b> (ie. Endurance and capability for ambulation, transfer, and managing activities for daily living)</p>	
<p><b>Strengths and Effective Strategies</b> (ie. What has worked in the past, what do you pride yourself in, etc.)</p>	
<p><b>Vulnerabilities /Risk Management</b> (ie. Communication, abuse, financial, safety, housing, mobility)</p>	
<p><b>Behavioral Summary</b> (ie. SIB, aggression, property destruction, elopement, drug/alcohol use, sexual behavior, triggers, etc.)</p>	

<p><b>Physical Status</b> (Based on observation)</p>	
<p><b>Supervision Expectations</b></p>	<p><input type="checkbox"/> Can come and go from home/day center as they please (no supervision)</p> <p><input type="checkbox"/> Can leave unsupervised for up to ___ hours at a time</p> <p><input type="checkbox"/> Must have staff available to them at all times</p> <p>Notes:</p>
<p><b>Safety Check Expectations</b> (Indicate SI/HI/SIB ideation, plan, intent)</p>	<p>Visual Safety checks to be completed every ___ min/hrs during waking hours and every ___ min/hrs during sleep hours</p> <p>Capable of self-preservation? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Notes:</p>

**Additional Information** (Include any information you feel is important for us to know about this individual)

\_\_\_\_\_  
Signature of individual making the referral

\_\_\_\_\_  
Self/Title/Licensure

\_\_\_\_\_  
Printed name of individual making the referral

\_\_\_\_\_  
Date