State of Illinois
Illinois Department on Aging

Referral Form for Services and Supports

Referral Date: **Time:** **Agency Name:**
Staff Person Taking Referral:

PERSON MAKING THE REFERRAL:			
Name:			
Phone: ( )	Cell	Home	Work
E-mail:			
Relationship to Individual in need of supports and services:			

INDIVIDUAL IN NEED OF SERVICES AND SUPPORTS		
Name:	Age:	Date of Birth:
Address:	City:	Zip Code:
County:	Phone: ( ) Home Work Cell	
E-mail:		
If not English-speaking, preferred language:		
Do you live alone? Yes No	Safety issues (i.e. dogs)? Yes No Please describe:	
If not a home residence, please indicate the name and type of facility where the Individual is located.		
Facility Name:		
Facility Address: Assisted Living Supportive Living Program Long-term Care Facility (Nursing Home) Hospital Hospice Facility Other: Name:		

DOES THE INDIVIDUAL HAVE A SPOUSE? Yes No	If yes, Spouse Name:
Is spouse in need of services and supports? Yes No	Age of spouse?
Is there a friend/family caregiver or emergency contact that needs to be contacted? Yes No	
If yes, provide contact information (if known):	

DOES THE INDIVIDUAL HAVE ANY OF THE FOLLOWING?			
Legal Guardian	Yes	No	Unknown
Representative Payee	Yes	No	Unknown

Power of Attorney for Health Yes No Unknown
Power of Attorney for Financial Yes No Unknown
If yes, provide contact information (if known):
Is there a friend/family caregiver or emergency contact that needs to be contacted? Yes No
If yes, provide contact information (if known):
Is there any other individual at this residence that needs services and supports? Yes No
NOTE: If yes, complete a separate referral form if 60 or over. If under 60, refer to the proper state agency.
Name of other individual (if known):
Age of other individual (if known):

HEALTH INFORMATION:
Does the Individual have: Hearing loss? Yes No Unk. Vision Issues? Yes No Unk.
If yes, preferred method of communication (i.e., Interpreter, TTY Relay Services or Braille Assistance):
Has the Individual been told by a health care professional that they have any of the following?
Alzheimer's or any other type of dementia? Yes No Unknown
Mental Health Illness? Yes No Unknown
Physical Disability? Yes No Unknown
Intellectual/Developmental Disability? Yes No Unknown
Brain Injury (i.e., stroke, head injury, aneurysm)? Yes No Unknown

ADDITIONAL INFORMATION REGARDING THE INDIVIDUAL IN NEED OF SUPPORTS AND SERVICES
Reason for Referral (general concerns): *Please provide any additional information regarding the Individual in need of supports and services that may be helpful.*
Does the Individual receive any supports and services now? Yes No If yes, type of supports and services are received:
Is the Individual experiencing any problems with the current supports and services? Yes No Please explain:
Has the Individual or spouse served in the military? Yes No
Is the Individual aware of the referral? Yes No Unknown
Is the Individual in immediate danger? Yes No Unknown Explain:
Is the Individual in need of immediate assistance? Yes No Explain:
Does the Individual want someone else to be present during the home visit? Yes No If yes, who:

What would be the best time and method to contact the Individual (if known): Time: Phone: (   ) E-mail: