ADRC CLIENT REFERRAL FORM

Please send completed form, along with supporting documents, to:
Email: ADRCreferrals@lacrossecounty.org OR Fax: 608-785-5790

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

Phone Number: _____ **Date:** _____

Has verbal/written consent been obtained for this referral? ☐ Yes ☐ No

If yes, date of consent: _____ **Inpatient?** ☐ Yes ☐ No

Anticipated discharge date: _____ **D/C to SNF?** ☐ Yes ☐ No

Where: _____

Referral to Elevate for MA? ☐ Yes ☐ No **A referral to Elevate may streamline access to Medical Assistance (MA)

- **Please attach a completed authorization/release of information if applicable.**
- ***If client/patient is requesting Family Care/IRIS/long-term care functional screen, please attach current problem list/diagnosis list.***

Client/Patient Name: _____ **Address:** _____

DOB: _____ **City, State, Zip:** _____

Phone Number: _____ **Gender:** _____

Race/Ethnicity (optional): _____

Email (optional): _____

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:

☐ **Dementia Care Planning Consult** ☐ **Home-delivered Meals** ☐ **Other (describe below)**

Primary Diagnoses/Problem List:

(*If requesting a functional screen, please attach a full list of current diagnoses.)

Additional Comments: