

Waiver Services Referral Form

Referral Date:

PMI:

Person Making Referral

Name: _____

Phone: _____

Person Contact Information DOB:

Name: _____

Address: _____

City: _____ Zip: _____

Phone: _____

Email: _____

County/Tribe: _____

Primary Physician Contact

Clinic: _____

Name: _____

Clinic
 Address : _____

Phone: _____

Guardian Contact Information (Address Same as Above)

Guardian Name: _____

Relationship to Person: _____

Address: _____

City: _____ Zip: _____

Guardian Phone: _____

Guardian Email: _____

Fax: _____

Currently In Home	Goal to be in own Home
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Interpreter Needed: _____

County/Tribe/Contracted Entity:

Contact Name: _____

Contact Title: _____

Phone: _____

Email: _____

Fax: _____

Home Care Service	Home health aide
PDN	SN
PCA	OT, PT, RT or ST

Waiver Service	
Brain Injury	CAC
DD	CADI
AC	Elderly Waiver
CDCS	

Mental Health Service	ARMHS
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Other: _____

Person Disabilities/Goals and Special Instruction:

Goals and Special Instruction (related to referral need):

Predominant Diagnosis:	ICD-10 code:
Secondary Diagnosis:	ICD-10 code:

The findings above should be reviewed with any other professionals involved in your care, including your physician, occupational or physical therapist or speech pathologist. While there are many stores which may sell similar products, we recommend that you acquire your equipment from a dealer specializing in assistive technology. We have found that dealers who specialize in assistive technology are able to provide better selection and support than other retailers.