

Waisman WIN Referral Request Form

Date:

Individual's Name:

Last First M.I.

Address:

Street City Zip

Home Telephone #: () DOB: / / Age:

Gender: ☐ Male ☐ Female ☐ Other

Family Contact: Relationship to Individual:

Telephone#: () Email:

Identifying Information

CLTS Agency: IRIS Agency:

FFA:

Insurance Coverage: ☐ MA ☐ Medicare ☐ Private Insurance Company

Legal Information

Legal Gaurdian: ☐ Yes ☐ No

Guardian's Name:

Last First M.I.

Relationship: Telephone#: () Email:

Power of Attorney (POA) for Healthcare Created: ☐ Yes ☐ No POA Activated: ☐ Yes ☐ No

If yes, POA's Name:

Last First M.I.

Relationship: Telephone#: () Email:

Living Will on File: ☐ Yes ☐ No Community DNR Activated: ☐ Yes ☐ No

Service Information

Case Manager or IRIS Consultant: _____

Telephone#: (____) _____ Email: _____

Residential Provider: _____

Telephone#: (____) _____ Email: _____

Residential Case Manager: _____

Telephone#: (____) _____ Email: _____

Type of residential support provided: ☐ Live-in ☐ Overnight-sleep ☐ Overnight-awake ☐ Hourly

If hourly, how many hours per day? _____

Please describe situation: _____

Housemate(s): _____

Vocational Provider: _____ Contact Person: _____

Telephone#: (____) _____ Email: _____

Type of work or activities this person performs? _____

Work Schedule: _____ Where is work performed? _____

School Attending:

Teacher: _____ Telephone#: (____) _____ Email: _____

School Nurse: _____ Telephone#: (____) _____ Email: _____

School Schedule: _____

Does this person receive MAPC hours? ☐ Yes ☐ No If yes, how many per week? _____

MAPC assistance given for what tasks? _____

Other, please describe (i.e. Home Health nursing, physical therapy, massage therapy, etc): _____

Individual Information

Height: _____ Weight: _____ Allergies: _____

Primary Diagnosis: _____

Other medical or psychiatric concerns: _____

Please describe individual's favorite activities or interest: _____

Capabilities (Please check all boxes that apply)

a. **Mobility:** Individual ambulates independently? ☐ Yes ☐ No

Person uses: ☐ Manual wheelchair ☐ Electric wheelchair ☐ Walker ☐ Cane

☐ Other (please describe):

Transfers: ☐ Independently ☐ Pivot w/assist ☐ Mechanical lift

Comments (i.e. type of lift, description of transfer):

b. **Communication:** Understands Speech ☐ Yes ☐ No Comments:

Speaks: ☐ Yes ☐ No ☐ Conversational ☐ Limited speech ☐ Vocalizations

Comments:

☐ Non-Verbal ☐ Eye Blinks ☐ Gestures ☐ Manual Signing ☐ Communication Board ☐ Communication Device

☐ Other/Comments

Able to read: ☐ Yes ☐ No Comments:

English is secondary language: ☐ Yes ☐ No Comments:

c. **Sensory Impairments:** ☐ Partially Deaf ☐ Deaf ☐ Visually Impaired ☐ Blind ☐ Color Blind

☐ Tactile Defensive – Please explain:

Sensory aids used: ☐ Hearing Aid ☐ Glasses ☐ Contacts

☐ Other (describe):

d. **Behavior:** Is this person seen by Waisman TIES staff? ☐ Yes ☐ No If yes, whom?

☐ Non-compliance ☐ Self-injurious behaviors ☐ Physical aggression towards others

☐ Destruction of property ☐ Physically resistive to cares ☐ Other, please explain

Please list any other helpful information such as stress factors, approaches or strategies which WIN nurses could use when interacting with the individual:

Medical History and Current Condition

Seizures: History of seizures: ☐ Yes ☐ No Last Seizure Date: / / Frequency of Seizures:

Does individual have a Vagus Nerve Stimulator? ☐ Yes ☐ No Is a seizure rescue med available? ☐ Yes ☐ No

Who is the doctor that oversees this individual's seizure disorder?

Physician Name: Clinic Name:

Clinic Address:
Street City Zip

Please explain seizures in detail (i.e., triggers, frequency, duration, any unique characteristics, describe what is seen):

Diabetes Mellitus: ☐ Yes ☐ No If yes: ☐ Type I ☐ Type II Insulin dependent: ☐ Yes ☐ No

Which medical provider manages diabetes orders?

What times of day are the person's blood sugars checked?

Who performs glucose monitoring? (please check all that apply):

☐ Individual ☐ Home Staff ☐ Vocational Staff ☐ Family

☐ Other (please explain):

If individual is insulin dependent, who administers insulin injections? ☐ Individual ☐ Staff

Does the person have a glucose monitor or insulin pump? ☐ Insulin pump ☐ CGM

Special feeding needs: ☐ Yes ☐ No If yes, explain (i.e. requires setup, must be spoon fed):

Please describe individual's diet:

Gastrostomy information: ☐ J tube ☐ G tube Feeds: ☐ Bolus ☐ Pump

Who changes tube?

Recent weight gain/loss: ☐ Yes ☐ No

Bladder Control: ☐ Continent ☐ Incontinent History of urinary tract infections? ☐ Yes ☐ No

Requires catheterization? ☐ Yes ☐ No If yes, explain frequency, who performs the procedure?

Comments: _____

Name of Pharmacy: _____ Telephone#: (____) _____

Primary Care Physician Name: _____

Telephone #: ()

Psychiatrist Name:

Telephone #: ()

Name: _____

Telephone #: ()

Name of hospital individual uses:

Has this individual been hospitalized in the past year? ☐ Yes ☐ No How many times?

Reasons for hospitalizations:

Please feel free to list any significant health changes, surgeries or special information you feel the WIN nurses should be aware of:

Primary reason for referral:

Best time of day for a nursing visit (Monday – Friday):

Person completing this form:

Relationship to the Individual:

Address:

Street City Zip

Telephone #: ()

Person to contact to start WIN services: