Interfaith Caregivers
Faith in Action In Faribault Co.
Neighbors helping Seniors maintain Independence, Dignity and Quality of Life

Care Receiver/Caregiver REFERRAL FORM

COMPLETE AND FAX TO 507-526-4442

Referrer Information

Referral made by: _____ Date: ___/____/___

Agency: _____ Phone: _____

Care Receiver Information

Name: _____ ❒ Male ❒ Female DOB: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

Served in Military: ❒ Yes ❒ No Spouse Served in Military: ❒ Yes ❒ No

Services Recommended/ Requested: ❒ Transportation ❒ Grocery Delivery ❒ Companion ❒ Homemaking/Chore ❒ Alert link ❒ Risk Assessment/Consultation ❒ Information/Referral

Present Support Systems: ❒ Medical Assistance ❒ Elderly Waver ❒ Alternative Care ❒ Veteran's Benefits ❒ Other:

Health Assessment:

Mobility: ❒ Needs No Assistance ❒ Cane ❒ Walker ❒ Wheelchair/scooter

Cognition: ❒ Alert/Oriented ❒ Occasional Minor Confusion ❒ Alzheimer's ❒ Other_____

Communication: ❒ Impaired Vision ❒ Impaired Hearing ❒ Impaired Speech. Explain:_____

Emotional: ❒ Depression ❒ Anxiety ❒ Stress ❒ Isolation ❒ Grief/loss ❒ Mood Disorder

Living at Home Assessment

Needs help with ADLs: ❒ Walking ❒ Bathing ❒ Getting out of Bed/Chair ❒ Eating ❒ Dressing ❒ Bath rooming

Sustained injurious fall within 6 months: ❒ Yes ❒ No

Has family member/friend who can help if needed: ❒ Yes ❒ No

Does family caregiver feel stressed or overwhelmed? ❒ Yes ❒ No

Has considered moving to nursing facility or assisted living: ❒ Yes ❒ No

Lives ❒ Alone ❒ with Spouse ❒ with other family members

Has concern about memory, thinking, or decision making? ❒ Very Concerned ❒ Somewhat Concerned ❒ No

Caregiver/Emergency Contact Information

Name: _____ ❒ Male ❒ Female DOB: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

Relationship to Client: _____

Services Recommended/ Requested: ❒ Individual Consulting ❒ Support Group/Education ❒ In-Home Respite

Other Information/Reasons for Request