

# Paradigm Residential Services, Inc

P.O. Box 63  
Princeton MN 55371  
763-856-7700  
763-856-7701 Fax

## CONSUMER REFERRAL FORM

NAME(First, Middle, Last): \_\_\_\_\_ MALE: \_\_\_\_\_ FEMALE: \_\_\_\_\_

PRESENT ADDRESS: \_\_\_\_\_

SOCIAL SECURITY #: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_ PHONE: \_\_\_\_\_

MA #: \_\_\_\_\_ WAIVER?: \_\_\_\_\_

CASE MANAGER: \_\_\_\_\_ ADDRESS/PHONE: \_\_\_\_\_

COUNTY OF RESPONSIBILITY: \_\_\_\_\_

PSYCHIATRIST: \_\_\_\_\_ ADDRESS/PHONE: \_\_\_\_\_

DIAGNOSIS: \_\_\_\_\_

STATE HOSPITAL/REGIONAL TREATMENT CENTER(MOST RECENT ADMISSION): \_\_\_\_\_

INPATIENT NON STATE HOSPITAL ADMISSION(DURING THE PAST 3 YEARS): \_\_\_\_\_

DAY TREATMENT INVOLVEMENT: \_\_\_\_\_

VOCATIONAL INVOLVEMENT: \_\_\_\_\_

CURRENT SERVICE PROVIDER/CONTACT PERSON: \_\_\_\_\_

- ADDRESS/PHONE: \_\_\_\_\_

Is client currently under commitment? YES \_\_\_\_\_ NO \_\_\_\_\_ Expiration Date: \_\_\_\_\_

GUARDIANSHIP: \_\_\_\_\_ REP PAYEE: \_\_\_\_\_

FUNDING SOURCE: \_\_\_\_\_ AMOUNT: \_\_\_\_\_

**Please fax/mail most recent Medications, Psychiatric Evaluation, Social History, and Neurological/Psychological Evaluation if available. Physical and Mantoux are required within 30 days prior to admission.**

**PLEASE DESCRIBE PRESENTING PROBLEM OR VULNERABILITIES (Complete applicable areas only)**

COMMUNITY INTEGRATION	
MEDICATION MONITORING/EDUCATION	
BEHAVIOR MANAGEMENT (VERBAL/PHYSICAL AGGRESSION)	
INDEPENDENT LIVING SKILLS	
SYMPTOMS MANAGEMENT	
MOBILITY STATUS	
SELF-CARE (ADL'S)	
GENDER/SEXUAL ISSUES	
VOCATIONAL FUNCTIONING	
SOCIAL FUNCTIONING	
SUBSTANCE ABUSE	
MEDICAL/DENTAL NEEDS (SPECIAL DIET)	

**DOES CLIENT KNOW OF THIS REFERRAL?** YES \_\_\_\_\_ NO \_\_\_\_\_

**REFERRED BY:** \_\_\_\_\_ **PHONE:** \_\_\_\_\_

**DATE FORM COMPLETED:** \_\_\_\_\_