Catholic Charities
Independent
Support Services

Submit by **Mail:** **Catholic Charities**
Independent Support Services
PO Box 10660
Portland, ME 04104-6060
Fax: **(207) 299-1930**

Referral Form

- Our purpose is to help consumers live independently at home
- Consumers must be physically unable to complete their own homemaking tasks
- Services are provided no less than 8 hours a month on a long-term basis

Form must be filled in <u>completely</u> in order to process. Please write "N/A" where appropriate.

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1. Name of Consumer: _____ 2. DOB: _____

Name of Spouse: _____ DOB:_____

3. Address of Consumer: _____

4. Total Number in Household: _____ 5. Phone # of Consumer: _____

6. Name, Agency & Phone # of person making referral, if other than consumer:

_____

7. Emergency Contact Name, Relationship and Phone #: (Should emergency contact be called on Consumer's behalf? ☐)

_____

8. (For those referring on behalf of Consumer) Does Consumer know they are being referred? _____

9. Does Consumer have less than $50,000 in liquid assets (or less than $75,000 for a couple?) _____

10. Does Consumer know someone who could be their homemaker? Name: _____

11. Is Consumer currently on a waitlist for a Maximus assessment? _____

Agencies/Services involved with consumer:_____

Caregiver Status:

☐ **Primary Caregiver receives help from family or friends.**

☐ **Primary Caregiver is unable to continue because _____**

_____

Consumer's IADL/ADL's Performance Scale:

Place number on the line which most closely describes consumer's present performance level.

1. Independently 2. Some Difficulty 3. Great Difficulty 4. Someone else must assist

_____ Laundry

_____ Meal Preparation

_____ Grocery shopping

_____ Errands

_____ Light house cleaning

_____ Taking out trash

_____ Limited Assistance with Personal Hygiene, such as: combing/washing hair, washing face, putting on jacket or shoes to go out

Other _____

(Continue on back)

Medical Information:

Heart/Circulation	**Current**	**History**
Congested Heart Failure		
Deep Vein Thrombosis		
Lymphedema		
Peripheral Vascular Disease		
Coronary Artery Disease		
Musculoskeletal		
Rheumatoid Arthritis		
Osteoarthritis		
Osteoporosis		
Fibromyalgia		
Muscular Dystrophy		
Missing Limb (i.e. amputation)		
Neurological		
Traumatic Brain Injury		
Alzheimer's		
Dementia		
Aphasia		
Cerebral Palsy		
Multiple Sclerosis		
Parkinson's Disease		
Transient Ischemic Attack		
Stroke		
Endocrine/Metabolic		
Diabetes Mellitus		
Hyperthyroidism		
Hypothyroidism		
Pulmonary		
Emphysema		
COPD		
On Oxygen		
Pulmonary Vascular Disease		
Sensory		
Macular Degeneration		
Glaucoma		
Cataracts		
Diabetic Neuropathy		
Hard of Hearing		
Deaf		
Legally Blind		

Cancer: Type: _____Current □ History □ Type: _____Current □ History □

Surgeries: Yes □ No □ 1. _____ 2. _____ 3. _____

Currently on Dialysis: Yes □ No □

Assistive devices used daily : □ Cane □ Wheelchair □ Walker/ Rollator □ Hearing Aids □ Other: _____

Other physical limitations: _____

_____