



Submit by Mail: Catholic Charities  
 Independent Support Services  
 420 Cumberland Ave  
 Portland, ME 04101  
 Fax: (207) 299-1930  
 Email: ISSReferral@ccmaine.org

**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 completely in order to process. Please write "N/A" where appropriate.\***

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 CHANGE/GOOLD Health Systems 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	_____ Grocery shopping
_____ Meal Preparation	_____ Banking
_____ Meal Planning	_____ Picking up prescriptions

\_\_\_\_\_ Light Housecleaning  
 \_\_\_\_\_ Washing floors/vacuuming  
 \_\_\_\_\_ Cleaning bathtub/shower, toilet  
 \_\_\_\_\_ Changing/Making bed

\_\_\_\_\_ Taking out trash  
 \_\_\_\_\_ Limited Assistance with Personal Hygiene,  
 such as: combing/washing hair, washing face,  
 putting on jacket or shoes to go out  
 Other \_\_\_\_\_

**Medical Information:**

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

**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:** \_\_\_\_\_