



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: _____ APS _____ Step-Down

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 U _____ 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 _____ -

_____ O = _____ ing
 _____ u ing t

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

Other _____

Medical Information:

Heart/Circulation

Current History

Congestive 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

Current History

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: _____