BUCKEYE HILLS regional council

Today's Date: _____

Referral Form

Please complete the following referral form in its entirety and fax to Buckeye Hills Regional Council.

If referral is coming from a doctor's office, home health agency or facility, please include demographic/face sheet, medications and diagnosis list.

Fax: 740-373-1594

Referral Source's Information

Name: _____ Phone: _____

Provider/ Agency, if applicable: _____

Individual's Information

Name: _____ Gender: _____

Address: _____

City: _____ State: _____ Zip: _____ County: _____

Phone: _____ DOB: _____ SS#: _____

Emergency Contact: _____ Phone: _____

Who should be contacted, the individual or someone else? _____

Primary Care Physician : _____ Phone: _____

Does individual need or receive any help with the following:

- ☐ Bathing
- ☐ Dressing
- ☐ Toileting (including managing ostomy/colostomy)
- ☐ Grooming (toenails, fingernails, hair)
- ☐ Moving around inside the home
- ☐ Eating
- ☐ Homemaking (dishes, laundry, sweeping, etc.)
- ☐ Managing money
- ☐ Getting/using transportation resources
- ☐ Prepare basic meals (sandwiches, frozen meals)
- ☐ Shopping for groceries, clothes or household items
- ☐ Medication Management. If checked, specify type of assistance needed: _____

Does the individual have Medicaid: _____ If not, is the individual willing to apply: _____

Other Concerns: _____