

**THOMAS ALLEN, INC.**  
**1550 HUMBOLDT AVENUE**  
**WEST ST. PAUL, MN 55118**  
**(651) 450-1802 FAX (651) 450-7923**  
**www.thomasalleninc.com**

## **REFERRAL QUESTIONNAIRE**

THANK YOU FOR YOUR INTEREST IN THOMAS ALLEN, INC.

TO ENABLE US TO BEGIN THE REFERRAL PROCESS, WE ASK THAT THE ATTACHED QUESTIONNAIRE BE COMPLETED BY THE APPLICANT'S PARENTS, CASE MANAGER OR CURRENT RESIDENTIAL PROVIDER.

PLEASE ANSWER ALL QUESTIONS. IF ANY QUESTION IS NOT APPLICABLE, INDICATE AN "NA" RESPONSE OR "U" FOR UNKNOWN. INCOMPLETE FORMS MAY DELAY THE REFERRAL PROCESS.

RETURN THE COMPLETED APPLICATION FORMS TO THOMAS ALLEN, INC. AT THE ABOVE ADDRESS.

### **Client Referral Information/Preferences for Services**

Client Name: \_\_\_\_\_

County of Service: \_\_\_\_\_

County of Financial Responsibility (if different): \_\_\_\_\_

Desired Timeline for Service Initiation: \_\_\_\_\_

Type of Service Desired (Check any applicable):

- Supportive Living Services – SLS (waiver with 24-hour foster care services)
- Waiver Services (less than 24-hour services with no foster care services)
- In-Home Support Services (services provided in family home or foster care home, less than 24-hour services each day)
- Semi-Independent Living Services – SILS (services provided in client home, with less than 7 days a week contact.)
- Intermediate Care Facility – ICF (Supervised Living Facility)
- Independent Living Services: Traumatic Brain Injury Services – TBI or CADI Waiver (Services provided in client home, with less than 7 days a week contact).

APPLICATION DATE: \_\_\_\_\_

NAME: \_\_\_\_\_ PROGRAM: \_\_\_\_\_

\_\_\_\_\_ address \_\_\_\_\_ telephone \_\_\_\_\_

LANDLORD: \_\_\_\_\_ address \_\_\_\_\_ telephone \_\_\_\_\_

SOCIAL SECURITY NUMBER: \_\_\_\_\_ ADMISSION DATE: \_\_\_\_\_

BIRTHDATE: \_\_\_\_\_ BIRTHPLACE: \_\_\_\_\_

HAIR COLOR: \_\_\_\_\_ EYE COLOR: \_\_\_\_\_ RELIGION: \_\_\_\_\_

RACE: \_\_\_\_\_ MARITAL STATUS: \_\_\_\_\_ GUARDIANSHIP STATUS: \_\_\_\_\_

PRIMARY DIAGNOSIS/CODE: \_\_\_\_\_ SECONDARY DIAGNOSIS: \_\_\_\_\_

ALLERGIES: \_\_\_\_\_

FINANCIAL RESPONSIBILITY-COUNTY: \_\_\_\_\_ SERVICING COUNTY: \_\_\_\_\_

PMI #: \_\_\_\_\_ MEDICARE #: \_\_\_\_\_

MEDICARE D PLAN: \_\_\_\_\_ PLAN ID#: \_\_\_\_\_ CONTRACT ID #: \_\_\_\_\_

OTHER (TYPE & POLICY #): \_\_\_\_\_ INCOME SOURCES: \_\_\_\_\_

METRO MOBILITY NUMBER: \_\_\_\_\_

MINNESOTA STATE ID NUMBER \_\_\_\_\_

**SERVICE COORDINATION WITH OTHER LICENSE HOLDERS**

CONTACT PERSON	ADDRESS	PHONE	SERVICE PROVIDED	SERVICE REQUIRING COORDINATION
			Case Management	ISP
			Vocational/Education	Day Program/School
			Residential	PIP
			County Financial Worker	Financial
			Social Security Claims Representative	Social Security Benefits
			DRS Counselor	Vocational

MEDICAL SERVICES

	NAME	ADDRESS	TELEPHONE
Hospital			
Clinic / Physician			
Dentist			
Neurologist			
Psychologist			
Psychiatrist			
Eye Doctor/Ophthalmologist			
Audiologist			
Other Specialists: (Indicate type)			

RELATIVES/ADVOCATES/LEGAL REPRESENTATIVES:

<u>RELATIONSHIP</u>	<u>NAME</u>	<u>ADDRESS</u>	<u>TELEPHONE</u>	<u>EMERGENCY CONTACT?</u>
FATHER				YES <input type="checkbox"/> NO <input type="checkbox"/>
MOTHER				YES <input type="checkbox"/> NO <input type="checkbox"/>
				YES <input type="checkbox"/> NO <input type="checkbox"/>

**Medical Information**

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Diet: \_\_\_\_\_ Known Allergies: \_\_\_\_\_

Does person have a Do Not Resuscitate (DNR), Do Not Intubate (DNI) or other Advanced Care Directive?

No  Yes – If Yes, a copy will need to be provided prior to admission

Seizure Condition:  No  Yes Smoking (amount/day): \_\_\_\_\_

If Yes, complete Seizure Plan of Care (on the following pages)

**Chronic Medical Problems/Complaints**

**Current Treatment**

- |    |       |       |
|----|-------|-------|
| 1. | _____ | _____ |
| 2. | _____ | _____ |
| 3. | _____ | _____ |

Has client been hospitalized for illness / injury/ surgery? If Yes, explain.

Date	Reason for Hospitalization	Hospital Name and Address

**Current Medications / Treatments**

Medication/Treatment	Purpose	Dosage	Precautions/Side Effects

Level of Medication Administration Support:

Client can take medication independently

Client requires staff observation

Client requires verbal reminders to take medication

Staff must administer all medication

Other significant past medications: Yes \_\_\_\_\_ No \_\_\_\_\_

If Yes, list name of medication(s), dose, frequency, and reason for use:

NAME	DOSE	FREQUENCY	REASON

**Psychotropic Medication History**

Has client ever been prescribed a medication to control behavior or alter their mood? (Psychotropic Medication)

Yes \_\_\_\_\_ No \_\_\_\_\_

If Yes, complete the following:

Name of Medication	Dose prescribed	Target behavior/condition for which it was prescribed	Dates of Use	Result

Date of Last DISCUS (Tardive Dyskinesia Assessment): \_\_\_\_\_

Date of Last MOSES (Monitoring of Side-Effects Scale): \_\_\_\_\_

**Exam Schedule**

Type	Frequency	Date of Last Visit	DUE MO/YR
Physical			
Eye			
Dental			
Neurologist			
Psychiatrist			
Psychologist			

## Family History

History of illnesses such as diabetes, high blood pressure, or occurrence of heart attack, stroke or cancer at age 60 or younger.

Relative: \_\_\_\_\_ Problem: \_\_\_\_\_

Relative: \_\_\_\_\_ Problem: \_\_\_\_\_

Relative: \_\_\_\_\_ Problem: \_\_\_\_\_

Will client accurately report illness or injury?  Yes - describe method  No - please explain

Does client cooperate with health care providers or medical treatments?  Yes  No

### Immunization Record

Immunizations Prior to Admission	Dates	Comments
DPT or DT		
Tetanus		
IM and Oral Polio		
Small Pox		
Influenza		
Measles Vaccine (Rubeola)		
Rubella Vaccine		
Mumps		
MMR (Measles, Mumps, Rubella)		
Hepatitis Antigen Screen (on admission if not prior to)		
Mantoux (PPD or Tubersol)		
Other:		

List specific information regarding the client's seizure history and current plan of care. This plan will be reviewed by the client's physician / neurologist.

**SEIZURE PLAN OF CARE**

Type of Seizures: \_\_\_\_\_

Current Seizure Medication(s): \_\_\_\_\_

Describe Typical Seizure and Seizure History (include date of last recorded seizure):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Length of Typical Seizure and Usual Seizure Frequency:

\_\_\_\_\_  
\_\_\_\_\_

General Plan of Care

1. Anticonvulsant medications will be administered as prescribed. Physician will be notified of all omitted doses.
2. Blood levels will be drawn as ordered by the physician, recommended at least yearly.
3. All seizure will be documented. The following information will be noted as needed per doctor's order: date, time, length of seizure, specific body movements and behaviors exhibited during the seizure, and after the seizure.
4. First aid for seizures will be administered as necessary.
5. All staff will receive training on specific client seizure plans.

Specific Plan of Care (procedures specific to the client)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Seizure Precautions:

(care taken beforehand and actions to observe which may indicate an upcoming seizure)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Employment or School History

(Please provide information in chronological order, with most recent information listed first.)

EMPLOYER: \_\_\_\_\_ SUPERVISOR: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_ TELEPHONE: \_\_\_\_\_  
OTHER AGENCY INVOLVED: \_\_\_\_\_  
JOB COACH (if applicable) \_\_\_\_\_ TELEPHONE: \_\_\_\_\_  
STARTING DATE: \_\_\_\_\_ ENDING DATE: \_\_\_\_\_  
STARTING WAGE: \_\_\_\_\_ HOURS WORKED: \_\_\_\_\_  
WAGE CHANGES: \_\_\_\_\_ ENDING WAGE: \_\_\_\_\_  
TITLE/DUTIES: \_\_\_\_\_  
BENEFITS: \_\_\_\_\_ TRANSPORTATION: \_\_\_\_\_  
REASONS FOR LEAVING: \_\_\_\_\_  
COMMENTS: \_\_\_\_\_

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EMPLOYER: \_\_\_\_\_ SUPERVISOR: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_ TELEPHONE: \_\_\_\_\_  
OTHER AGENCY INVOLVED: \_\_\_\_\_  
JOB COACH (if applicable) \_\_\_\_\_ TELEPHONE: \_\_\_\_\_  
STARTING DATE: \_\_\_\_\_ ENDING DATE: \_\_\_\_\_  
STARTING WAGE: \_\_\_\_\_ HOURS WORKED: \_\_\_\_\_  
WAGE CHANGES: \_\_\_\_\_ ENDING WAGE: \_\_\_\_\_  
TITLE/DUTIES: \_\_\_\_\_  
BENEFITS: \_\_\_\_\_ TRANSPORTATION: \_\_\_\_\_  
REASONS FOR LEAVING: \_\_\_\_\_  
COMMENTS: \_\_\_\_\_

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EMPLOYER: \_\_\_\_\_ SUPERVISOR: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_ TELEPHONE: \_\_\_\_\_  
OTHER AGENCY INVOLVED: \_\_\_\_\_  
JOB COACH (if applicable) \_\_\_\_\_ TELEPHONE: \_\_\_\_\_  
STARTING DATE: \_\_\_\_\_ ENDING DATE: \_\_\_\_\_  
STARTING WAGE: \_\_\_\_\_ HOURS WORKED: \_\_\_\_\_  
WAGE CHANGES: \_\_\_\_\_ ENDING WAGE: \_\_\_\_\_  
TITLE/DUTIES: \_\_\_\_\_  
BENEFITS: \_\_\_\_\_ TRANSPORTATION: \_\_\_\_\_  
REASONS FOR LEAVING: \_\_\_\_\_  
COMMENTS: \_\_\_\_\_

## Financial Information

Assets and / or Policies Client Possesses:

Type	Yes	No	Location	Amount	Account #
Checking Account					
Savings Account					
Prepaid Burial Account					
Burial Plot					
Health Insurance					
Life Insurance					
Rental Insurance					

Current Income Sources:

Type	Yes	No	Amount	Payee	When received
Social Security – RSDI					
SSI					
MSA					
MA (Minnesota Health Care)					
Medicare					
Parents					
Other:					
Other:					

Money Management:

Skill	Level of Independence				
	Independent	A Reminder	Verbal Cue(s)	Physical Cue(s)	Total Assistance
Coin Identification					
Currency / Bill Identification					
Knows purpose / value of money (purchases or sells items for reasonable amounts of money)					
Carries and stores money or valuables safely					
Has sufficient money when making or ordering purchases					
Savings account use / maintenance					
Checking writing					
Checking account reconciliation					
Bill paying					
Welfare or payroll checks					
Budgeting skills					
Processing Personal Mail					

Describe general spending habits, current debts, issues with problem spending, loans to others, borrowing or theft of money:

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**Personal and Community Safety**

Skill	Level of Independence				
	Independent	A Reminder	Verbal Cue(s)	Physical Cue(s)	Total Assistance
Informs caregiver before leaving without supervision					
Immediately withdraws from painful stimuli (heat, flames, etc.)					
Takes reasonable precautions with strangers					
Practices street safety skills					
Practices bike safety skills					
Travels safely while in vehicles (uses seat belts, etc)					
Seeks help if lost from a responsible person					
Relates identifying information and presents ID					
Responds to warning devices sighted or sounded to identify dangerous conditions or situations (barricade, tornado, siren, fire alarm, etc)					
Avoids dangerous machinery					
Avoids dangerous conditions or situations (social, sexual, or environmental)					
Avoids abusive use of tobacco, alcohol, or drugs					
Follows directions in dangerous circumstances					
Uses public transportation (i.e. bus system, taxi, etc.)					

Comments:

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**Mobility / Range of Motion**

Does client have a medical / physical condition which impairs ambulation, balance, coordination and/ or range of motion?

No

Yes

If Yes, describe adaptive equipment used (i.e. orthopedic shoes, walker, braces, wheelchair, cane, etc.) and level of assistance /supervision needed. Also, indicate names of suppliers and dates purchased/received.

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Does client have any physician ordered activity restrictions?

No

Yes

**Diet Management**

Does client consume only edible, properly prepared foods and beverages?

Yes

No, explain

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Does client have any chewing or swallowing limitations?

No

Yes, please explain

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List clients' food preferences and dislikes:

Preferences: \_\_\_\_\_

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Dislikes: \_\_\_\_\_

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## Diet Management (continued)

TASK	LEVEL OF INDEPENDENCE				
	Independent	A Reminder	Verbal Cue(S)	Physical Cue(S)	Total Assist.
Meal Planning					
Cooking					
Eating Balanced Meals – appropriate portion control based on body needs					
Table Manners (use of utensils, glass / cup)					
Eating					
Grocery Shopping					
Uses Stove					

Comments:

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## Domestic Care

TASK	LEVEL OF INDEPENDENCE				
	Independent	A Reminder	Verbal Cue(S)	Physical Cue(S)	Total Assist.
Cleanup of personal items					
Household cleaning items					
Laundering Clothes					

Comments:

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## Self Care

TASK	LEVEL OF INDEPENDENCE				
	Independent	A Reminder	Verbal Cue(S)	Physical Cue(S)	Total Assist.
Bathing					
Hair Care					
Tooth Brushing					
Hand Washing					
Toileting					
Dressing – selection (all conditions)					
- putting on					
Menstrual Care (if applicable)					
Shaving					
Nail Care					

Comments:

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## Communication

Mode used and current level: (check all that apply)

Verbal                       Written                       Sign Language  
 Gestures                       Communication Device (describe) \_\_\_\_\_

Responds to simple instructions?                       Yes                       No

Answers verbal questions?                       Yes                       No

Able to converse and understand others?                       Yes                       No

Able to use phone independently?                       Yes                       No

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Socialization / Leisure/ Recreation

Favorite indoor leisure pursuits/hobbies: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Favorite outside/community activities: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

General Personality Characteristics: (check which apply)

Outgoing, extroverted                       Sociable                       Energetic                       Leader  
 Passive, introverted, shy                       Prefers to be alone                       Relaxed                       Follower

Indicate whether the client exhibits the following behaviors: (check all that apply)

Self-injurious                       Verbally aggressive                       Physically aggressive                       Destroys property  
 Sexually inappropriate                       Passive/easily led                       Overly familiar with strangers

Comments: (Discuss frequency & intensity of these behaviors, as well as what might trigger this behavior.)  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## **CLIENT CULTURE/VALUES HISTORY**

At Thomas Allen, Inc. we strive to help you maintain the values and traditions that have been a significant part of your life. Please take some time to answer the following questions.

1. How do you celebrate the following holidays?
  - a. New Year's Eve/Day:
  - b. Valentine's Day:
  - c. Easter/Passover:
  - d. Mother's Day/Father's Day:
  - e. Memorial Day:
  - f. Independence Day:
  - g. Labor Day:
  - h. Halloween:
  - i. Thanksgiving:
  - j. Hanukkah/Christmas/Kwansaa:
2. Do you have a religious affiliation? How do you typically observe?
3. What types of foods do you enjoy eating? Do you have any mealtime traditions?
4. What are some favorite activities that you share with family and/or significant others:
  - a. Community events/activities?
  - b. Sports?

c. Visiting family members?

d. In-home activities?

e. Board games?

f. Vacations?

5. Are there any individuals you would want to stay in contact with? (via, visits, letters, phone contacts?) Please include address and phone numbers.

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

6. Are there any birthdays/anniversaries that we should be aware of? What are your expectations with regard to observing family birthdays? (e.g., to whom would you like to send cards?) Please include addresses and phone numbers.

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

7. How do you typically celebrate birthdays?

8. Is there anything that we have missed? Please explain.