AHL HealthCare Group, Inc.
At Home Living Facilities, At Home Living Facilities Metro,
BRIDGES to Success, Wesley Residence of Duluth, Garden Terrace
Phone: 218-728-1189 Fax: 218-722-2325

Referral Form/Initial Intake Screening

Duluth Area:
Dustin Krech (CRS), Jen Anderson (Community referrals), Nancy Hillstrom (Assisted Living)
Tucker Lindberg (BTS-IRTS)
PO Box 16510 Duluth, MN 55816 Fax: 218-722-2325
Metro Area:
Casey Erickson (CRS, Community, Day Services)
1200 Osborne Rd Fridley, MN 55432 Fax: 763-786-4365
You can also visit our website at: www.ahlhealthcaregroup.com

Demographic Information **Location:**

Referral Name:	Would like services by:
Person making referral and preferred contact info:	
Referral Phone:	Referral email:
Referral current address:	
Seeking what services: ☐ Community Residential Setting (AFC/CRS) ☐ Assisted Living ☐ IRTS ☐ Community/unit-based ☐ Day Support Services	
Reason for referral:	
Where did you hear about our services?	
DOB:	SSN:
Legal Status: ☐ voluntary ☐ committed	Cultural/Spiritual considerations:
MA #:	Medicare #:
Funding Source:	Co. of financial responsibility:
Current symptoms and severity:	
Primary diagnosis:	Primary diagnosis code:
Other diagnosis:	

Contacts

Case Manager:	Name: Address: Phone: Fax: Email:
Guardian:	Name: Address: Phone: Fax: Email:
Other (ie social worker, ARMHS worker, primary care physician, Psychiatrist, therapist, emergency contact, probation officer, etc): Attach list if necessary	

Expectations of staff (What services do you want to see us provide/what is the goal for placement, etc.)

Social History (ie: family history, previous placements, employment history, support systems, etc.)	
Psychosocial Status (ie. Awareness level, personal care needs, need for privacy or socialization)	
Medical/Personal Hygiene Needs (ie. diabetes mgmt, dietary needs, hx communicable disease, incontinence, need for privacy, advance directive, upcoming appointments, etc.) Please attach a current prescription and OTC medication list including what is currently being taken.	
Functional Status (ie. Endurance and capability for ambulation, transfer, and managing activities for daily living)	
Strengths and Effective Strategies (ie. What has worked in the past, what do you pride yourself in, etc.)	
Vulnerabilities /Risk Management (ie. Communication, abuse, financial, safety, housing, mobility)	
Behavioral Summary	

(ie. SIB, aggression, property destruction, elopement, drug/alcohol use, sexual behavior, triggers, etc.)	
Physical Status (Based on observation)	
Supervision Expectations	☐ Can come and go from home/day center as they please (no supervision) ☐ Can leave unsupervised for up to ___ hours at a time ☐ Must have staff available to them at all times Notes:
Safety Check Expectations (Indicate SI/HI/SIB ideation, plan, intent)	Visual Safety checks to be completed every ___ min/hrs during waking hours and every ___ min/hrs during sleep hours Capable of self-preservation? ☐ Yes ☐ No Notes:

Additional Information (Include any information you feel is important for us to know about this individual)

_______________________________________ _______________________

Signature of individual making the referral Self/Title/Licensure

_______________________________________ _______________________

Printed name of individual making the referral Date