



## REFERRAL FOR SERVICES

Date of Referral:		Requested Service Start Date:	
<b>Identifying information</b>			
Name:		SS #	
Identified Gender:		MA #	
Identified Race:		PMI #	
DOB & Age:	DOB: / / AGE:	Financial County?	
Height & Weight	Ht:	Wt:	Billing Source?
<b>Contact information</b>			
<b>Person:</b> _____		<b>Parent/Guardian:</b> _____	
Address:		Address:	
Phone:		Phone:	
Email:		Email:	
<b>Case Manager:</b> _____		<b>Referral Source:</b> _____	
Address:		Address:	
Phone:		Phone:	
Email:		Email:	
<b>Why is this person being referred to Beacon for services?</b>			
<b>Background information</b>			
<b>What services are needed?</b>		<b>What staffing supports would be required?</b>	
<input type="checkbox"/> Foster Care-Adult or Child		<input type="checkbox"/> Residential 24 hour with Awake overnight staff	
<input type="checkbox"/> Respite Care-5 to 17 years		<input type="checkbox"/> Residential 24 hour with Sleep overnight staff	
<input type="checkbox"/> 90-day Crisis Stabilization-5 to 17 years		<input type="checkbox"/> Hourly/Intermittent/Unit based services.	
<input type="checkbox"/> 1:1 Individualized Home Based Supports		<input type="checkbox"/> Needs staffing aid in vehicle	
<b>About Me</b>			
<b>Likes – What do I need in my life:</b>			
<b>Dislikes – What do I not want in my life:</b>			
<b>What does a Good Day look like:</b>			
<b>What does a Bad Day look like:</b>			
<b>Additional Comments:</b>			

<b>Psychiatric/Medical Diagnoses</b>	
<b>Psych Diagnoses:</b>	
<b>Medical Diagnoses:</b>	
<b>Please list and describe any chronic health conditions:</b>	
<b>What kind of medical support does this person need?</b>	
<b>Does this client have a moratorium bed or are they looking to obtain one?:</b>	



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How often does this person seek medical services or support?	
Does this person have any mobility or ambulation challenges we should be aware of?	
IDD Level:	<input type="checkbox"/> Borderline <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Profound <input type="checkbox"/> RC <input type="checkbox"/> None
Additional Comments:	

Communication Style	
<input type="checkbox"/> Verbal <input type="checkbox"/> Limited <input type="checkbox"/> ASL <input type="checkbox"/> PECs <input type="checkbox"/> Written <input type="checkbox"/> No Functional Means of Communication	
Additional Comments:	
Self-Care/Hygiene Skills	
<input type="checkbox"/> Needs Full Assistance <input type="checkbox"/> Needs Verbal Prompts <input type="checkbox"/> Needs Occasional Reminders <input type="checkbox"/> Independent	
Additional Comments:	

Substance Use	
<input type="checkbox"/> Smokes/Vapes	Alcohol: <input type="checkbox"/> None <input type="checkbox"/> Use <input type="checkbox"/> Abuse <input type="checkbox"/> Historical <input type="checkbox"/> Unknown
Illegal Controlled Substances: <input type="checkbox"/> None <input type="checkbox"/> Use <input type="checkbox"/> Abuse <input type="checkbox"/> Historical <input type="checkbox"/> Unknown	
Substance Type(s):	
Additional Comments:	

Interfering Behavior(s)	
Physical Aggression Towards Others	
Level of Risk: <input type="checkbox"/> High <input type="checkbox"/> Medium <input type="checkbox"/> Low <input type="checkbox"/> None	Current Frequency & Duration of incidents:
Toward Whom:	
Description of Behavior:	
Self-Injurious Behaviors	
Level of Risk: <input type="checkbox"/> High <input type="checkbox"/> Medium <input type="checkbox"/> Low <input type="checkbox"/> None	Current Frequency & Duration of incidents:
Description of Behavior:	
Calling 911/Psychiatric Emergencies	
Level of Risk: <input type="checkbox"/> High <input type="checkbox"/> Medium <input type="checkbox"/> Low <input type="checkbox"/> None	Current Frequency & Duration of incidents:
Toward Whom:	
Description of Behavior:	
Suicidal Behaviors	
Level of Risk: <input type="checkbox"/> High <input type="checkbox"/> Medium <input type="checkbox"/> Low <input type="checkbox"/> None	Current Frequency & Duration of incidents:
Has Made: <input type="checkbox"/> Threats <input type="checkbox"/> Attempts	
Description of Behavior:	
Inaccurate Reporting	
Level of Risk: <input type="checkbox"/> High <input type="checkbox"/> Medium <input type="checkbox"/> Low <input type="checkbox"/> None	Current Frequency & Duration of incidents:
Is Typically an Accurate Reporter: <input type="checkbox"/> Yes <input type="checkbox"/> No	



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Description of Behavior:	
<b>Interfering Sexual Behavior</b>	
Level of Risk: <input type="checkbox"/> High <input type="checkbox"/> Medium <input type="checkbox"/> Low <input type="checkbox"/> None	Current Frequency & Duration of incidents:
Known Sexual Trauma? Yes or No or Unknown	
Comments:	
Typically Targets: <input type="checkbox"/> Staff <input type="checkbox"/> Peers <input type="checkbox"/> Males <input type="checkbox"/> Females <input type="checkbox"/> Other (Describe):	
Sexual Offender? Yes or No	
Description of Behavior:	
<b>Aggression Towards Property</b>	
Level of Risk: <input type="checkbox"/> High <input type="checkbox"/> Medium <input type="checkbox"/> Low <input type="checkbox"/> None	Current Frequency & Duration of incidents:
Description of Behavior: At grandmother's home	
<b>Verbal Aggression</b>	
Level of Risk: <input type="checkbox"/> High <input type="checkbox"/> Medium <input type="checkbox"/> Low <input type="checkbox"/> None	Current Frequency & Duration of incidents:
Follows Through on Verbal Threats: <input type="checkbox"/> Yes <input type="checkbox"/> No	Towards Whom:
Description of Behavior:	
<b>Elopes</b>	
Level of Risk: <input type="checkbox"/> High <input type="checkbox"/> Medium <input type="checkbox"/> Low <input type="checkbox"/> None	Current Frequency & Duration of incidents:
Where Does the Person Typically Go:	
Description of Behavior:	
<b>Breaks Laws</b>	
Level of Risk: <input type="checkbox"/> High <input type="checkbox"/> Medium <input type="checkbox"/> Low <input type="checkbox"/> None	Past or Pending Charges:
Has Made: <input type="checkbox"/> Threats <input type="checkbox"/> Attempts	
Police Involvement: <input type="checkbox"/> Yes <input type="checkbox"/> No	Combative Toward Officers: <input type="checkbox"/> Yes <input type="checkbox"/> No
Description of Behavior:	
Felony Convictions? Yes or No	
Probation Officer: Name:	Phone:                      Email:
<b>EUMR Use</b>	
Use: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Current Frequency & Duration of incidents:

Please return to:

**Beacon Specialized Living**

[Mnreferrals@beaconspecialized.org](mailto:Mnreferrals@beaconspecialized.org)

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