Date referral received:____/____/____

# SAFE

Records Requested [ ] Yes
DOE: _____

## Referral and Screening Form

Name of Patient: _____ Date of birth: _____/_____ /_____ Age: _____

SSN: _____ UNMH MRN: _____Gender: [ ] Male [ ] Female

DD Waiver: [ ] Yes [ ] No Other Waiver: _____

Primary Language (spoken at home): [ ] English [ ] Other: _____Needs interpreter: [ ] Yes [ ] No

Primary contact: Name: _____Home:_____Cell: _____
Best time to call: _____ Email:_____

Address: _____City: _____State:_____

Case Manager: Name: _____Phone: _____Email: _____
Guardian: Name: _____Phone: _____Email: _____
Res. Svc. Coord.: Name: _____Phone: _____Email: _____
PCP: Name: _____Phone: _____Email: _____

Therapists/Other:
Name: _____Phone: _____Email: _____
Name: _____Phone: _____Email: _____
Name: _____Phone: _____Email: _____
Name: _____Phone: _____Email: _____

Feeding/Eating concerns: _____

_____

_____

_____

_____

Feeding mode: [ ] Oral [ ] NPO [ ] G-tube [ ] Other: Comments: _____

Diet: [ ] Regular [ ] Soft [ ] Pureed [ ] Chopped [ ] Other _____

Swallow Study: [ ] Yes [ ] No Date of study:_____ Place of study: _____

History of Aspiration: [ ] Yes [ ] No

Diagnosis (es): _____

_____

***Referral received from:*** _____

**INSURANCE:_____ID#_____Grp#_____
Address:_____ City_____
Phone:_____ Contact:_____ Prior Approved: [ ] YES [ ] NO