University of Colorado Colorado Springs

HealthCircle **Aging Center**
4863 N Nevada Ave, Suite 321
Colorado Springs, CO 80918
Phone 719-255-8002
Fax 719-255-8006
www.uccs.edu/agingcenter

EVALUATE AND TREAT REFERRAL FORM

(Please complete and fax to: 719-255-8006)

Date of referral: _____/_____/_____

Name of person making referral and relationship to client: _____

Referring person's direct telephone number: _____

Can a message be left on this number? ☐ Yes ☐ No

CLIENT NAME: _____ DOB: ____/_____/_____ Age: _____

Address: _____City/State: _____Zip Code: _____

Phone#: H _____W _____C_____

Can we leave a message on these numbers? ☐ Yes ☐ No

Is client aware of referral? ☐ Yes ☐ No If No, why not: _____

_____

UCCS AGING CENTER SERVICE REQUESTED:

☐ Assessment for Capacity (page 2. must be completed)
☐ Assessment for Diagnosis (page .2 must be completed)
☐ Caregiver Therapy (therapy for issues associated with providing care for a loved one)
☐ Individual Psychotherapy
☐ Memory Clinic (screen for memory concerns, or to establish a baseline)

Reason(s) for seeking service (or attach referral):

_____

_____

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SCHEDULING CONTACT

(Complete this section if it is preferable to contact someone other than the referring provider/agency):

Contact the client to schedule ☐ Yes ☐ No **OR**

Name: _____

Relationship to Client: _____

Phone#: H _____*W* _____*C*_____

Can we leave a message on these numbers? ☐ *Yes* ☐ *No*

Has the client given permission for this person to be contacted regarding scheduling and information about the services being provided? ☐ *Yes* ☐ *No*

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EVALUATE AND TREAT REFERRAL FORM – PAGE 2 - ASSESSMENT SUPPLEMENT
(This page is needed if referring client for assessment)

ASSESSMENT FOR CAPACITY ONLY:

APS CASE NO:_____ DATE CASE OPENED: ___/___/___

DECISION-MAKING AND CAPACITY DIMENSION:

- ☐ independent living
- ☐ medical consent or health care decision
- ☐ financial affairs management
- ☐ make or alter legal documents
- ☐ Other (pls specify): _____

Is there a temporary/emergency guardian in place? ☐Yes ☐No

If YES above, a signed consent from guardian MUST BE ATTACHED
(Please call the Aging Center 719-255-8002 to request a Consent Form)

Attorney: _____

Date of Hearing: ____/_____/____

Is there court involvement with the case? ☐Yes ☐No
Is there a court hearing scheduled? ☐Yes ☐No
Is full guardianship at issue? ☐Yes ☐No
Is the evaluation to be used with a disability claim ☐Yes ☐No

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ASSESSMENT FOR CAPACITY AND/OR ASSESSMENT FOR PROBABLE DIAGNOSIS:

PSYCHO-SOCIAL DIMENSION:

- ☐ mental illness affecting functioning
- ☐ risk for exploitation
- ☐ alcohol or drugs affecting functioning
- ☐ employability
- ☐ learning disability

MEDICAL FACTORS:

- ☐ chronic pain affecting cognitive abilities
- ☐ medical condition(s) affecting cognition
- ☐ medication(s) affecting cognitive functioning
- ☐ physical disabilities or conditions affecting functioning

Is the evaluation to be used with a disability claim? ☐Yes ☐No

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BILLING:

If this service is to be charged to the client's **Medicare insurance** plan, please provide insurance details below:

Medicare Number (full number as show on Medicare card): _____

Client's name as it appears on Medicare card: _____

Name of Supplemental Insurer: _____

(Write NONE if client doesn't have a supplemental insurer)