Mail Form to:
Support Center
1625 East Market Street
York, PA 17403
717-747-9000

PLEASE PRINT

Please list which service this referral is for: _____

Individual's Name: _____

Address: _____

City: _____State: _____ Zip Code: _____

Phone #: _____ Social Security #: _____

Gender: _____ Date of Birth: _____ Race: _____ Religion: _____

Hair Color: _____ Eye Color: _____ Identifying Marks: _____

Language/Means of Communication: _____

Family/Guardian: _____

Address: _____

City: _____ State: _____ Zip Code: _____ Home Phone #: _____

Cell #: _____ Work #: _____ Email: _____

Please list emergency contacts

Name: _____ Phone #: _____

Name: _____ Phone #: _____

Primary Physician: _____ Phone #: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Hospital Preference: _____

Other Medical Providers: _____

Supports Coordinator: _____ Phone #: _____

List Type of Waiver: _____In What County: _____

Medical Issues

Diagnoses: _____

_____

_____

Level of disability: severe/moderate/mild (circle one)

Allergies: _____

_____

Seizures (if yes, please describe): _____

_____

Medical devices/adaptive equipment needed: _____

_____

Any other medical conditions/concerns: _____

_____

Please list medications: _____

_____

Self-medicating? _____

Any special instructions for administering medications? _____

_____

Any vision/hearing limitations? _____

Any sensory issues? _____

Behavioral Issues

If applicable, please describe any challenging behaviors: _____

_____

_____

Any antecedents or triggers for behaviors: _____

_____

Frequency: _____

Best way to handle behavior issues: _____

_____

_____

Food/meals/eating

Level of assistance needed when eating: _____

_____

Choking risk: _____

Any difficulty chewing or swallowing: _____

Any special food/drink preparation needed: _____

_____

Any dietary restrictions: _____

_____

Any adaptive devices used: _____

Daily Living Skills

(Please note – Independent, Verbal Prompts, Physical Prompts, or Total Assistance, as well as any adaptive equipment used)

Personal Care

Bathing: _____

Dressing: _____

Eating: _____

Taking medications: _____

Brushing teeth: _____

Toileting: _____

Ambulation: _____

Ability to care for personal belongings: _____

Housekeeping skills: _____

Safety Awareness

Street Safety: _____

Fire Safety: _____

Hot surfaces: _____

Hot water: _____

Poisons: _____

Strangers: _____

Sharps: _____

Emergency situations: _____

Can use 911: _____

Ingests non-edibles: _____

Ability to be left unsupervised and length of time: _____

_____

Social Skills

Able to get along with others: _____

Able to follow directions: _____

Ability to communicate wants/needs: _____

Preference for independent or group activities: _____

General emotional state: _____

List strengths: _____

_____

_____

List needs: _____

_____

_____

List activities enjoyed: _____

_____

_____

List other important information to know: _____

_____

_____

List community activities or involvements (church, volunteering, clubs, Special Olympics, etc.): _____

_____

_____