Community Living
And Support Services

Alliance for Community Respite Care

Referral Information Form

Date: _____

Phone: _____

Individual/Family Member
Name: _____

Date of Birth: _____

Gender: _____

Caregiver's Name: _____

Number of Caregivers at Home: _____

Address: _____

_____

Number of Siblings and Ages: _____

Type of Respite Requested: ____ Day ____Evening ____Emergency ____Overnight ____Other

Place of Service: ___In Home ___Out of Home ___Both/Either

Health Insurance: _____

Disability or Chronic Medical Problem (including mental health diagnosis):

_____

_____

Medical History: (current health status, medications, medical conditions and equipment)

_____

_____

Alliance for Community Respite Care of CLASS
1400 South Braddock Avenue
Pittsburgh, PA 15218

Phone: 412-683-7100, Ext. 4230
Toll Free: 1-888-954-2424

Email: acrc@classcommunity.org

Other special training required/needed by provider (example: seizure disorder, diabetes)

_____

_____

Does medication need to be dispensed during time of service?	___Yes	___No
Is special nursing care needed?	___Yes	___No
Ambulatory care?	___Yes	___No
Will physical assistance be needed?	___Yes	___No
If yes-	___Yes	___No
Visually Impaired?	___Yes	___No
Hearing Impaired?	___Yes	___No
Verbal?	___Yes	___No
Personal Hygiene: Use of Diapers	___Yes	___No
Is transportation needed during respite?	___Yes	___No
Special Diet/Feeding Needs:	___Yes	___No

If yes, please specify: _____

_____

_____

What other community programs are you involved with? _____

Anything else? _____

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