

# Bluegrass Aging and Disability Resource Center Professional Referral Form

## Client Information

First and Last Name

DOB

Age

Gender

Primary Phone Number

Name of contact (if not client)

Relationship to client

Alternate Phone Number

Street Address

City, Town, and Zip Code

Is the client a veteran?

Yes

No

Client's current living arrangement:

Lives with spouse

Lives alone

With child/children

Lives with parents

Other- please specify

How many people are in the client's household?

1

2

3

4 or more

Is the client homebound?

Yes

No

What services/programs are you referring the client for more information about:

Medicaid	Medicare	Home Delivered Meals
Personal Care	Respite Care	Medicaid Waiver
Homemaker	Transportation	Caregiver Support
Assistive Technology- DME, etc		Senior Center Services
Other- please specify		

Is there anything else you would like us to know? ex. Communication barriers, best times to contact

Name of person making referral

Agency or Organization Name

Primary Telephone Number

Best time to call if needed

Email address

Does the client know a referral is being made on his/her behalf?

Yes      No

If you have any questions related to this referral, please call the Aging and Disability Resource Center at 1-866-665-7921 or 859-266-1116 or email [adrc@bgadd.org](mailto:adrc@bgadd.org)