



723 N. Broad Street  
Fremont, NE 68025  
Phone: (402) 721-3125

## Referral Form (2/2025)

This form must be completed and returned by referring agency/staff **BEFORE** a client will be accepted. This form must be completed in its entirety when your client is being released/discharged from your agency or institution, or the potential client is from outside the service area. The referring agency and client **MUST** wait for approval from Care Corps LifeHouse before coming to LifeHouse. Approval will be sent via email as stated at the bottom of this form.

### Referring Agency Information:

Name of Agency: \_\_\_\_\_ Address: \_\_\_\_\_

Name of referring worker: \_\_\_\_\_ Phone: \_\_\_\_\_  
Email: \_\_\_\_\_

### Referred Client Information – only those listed on the referral will be considered:

Name of person being referred: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address prior to coming into current facility: \_\_\_\_\_

Phone: \_\_\_\_\_

Why is this person in your care ?

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Date of admission: \_\_\_\_/\_\_\_\_/\_\_\_\_

Date of scheduled discharged: \_\_\_\_/\_\_\_\_/\_\_\_\_

Any critical incidents?

YES

NO

If yes, please explain (use additional paper if needed):

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Was this person cooperative while in your care? (use additional paper if needed)

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Is the client on probation/parole?

YES

NO

If yes, who is the probation/parole officer? \_\_\_\_\_

What is the individual's current living situation? (Please check)

- ☐ Emergency Shelter
- ☐ Jail/Prison
- ☐ Drug/Alcohol Treatment
- ☐ Domestic Violence Shelter
- ☐ Medical Facility
- ☐ Family/Friends
- ☐ Eviction
- ☐ Other (please explain)

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What was the individual's address prior to entering your facility? \_\_\_\_\_

## Mental/Physical Health Information:

Is this person medically cleared and physically/mentally able and willing to take care of him/herself?

(The individual must be able to fully function independently) YES

NO

Explain how this looks daily:

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Please indicate which activities of daily living (ADL's) the individual can complete:

(Also, please note if assistance is needed with any ADL)

<b>Bathing</b>	YES	NO	W/Assistance	<b>Dressing</b>	YES	NO	W/Assistance
<b>Oral Care</b>	YES	NO	W/Assistance	<b>Toileting</b>	YES	NO	W/Assistance
<b>Eating</b>	YES	NO	W/Assistance	<b>Cooking</b>	YES	NO	W/Assistance
<b>Taking Meds</b>	YES	NO	W/Assistance	<b>Laundry</b>	YES	NO	W/Assistance
<b>Grooming</b>	YES	NO	W/Assistance	<b>Walking</b>	YES	NO	W/Assistance
<b>Housework</b>	YES	NO	W/Assistance				

Medication Use:

Is this client currently on any medications? YES NO  
If so, what medications and what are they for:

☐ Med list is attached.

Is medication being sent with the client? YES NO  
How long before a refill is needed? \_\_\_\_\_

Is client compliant with taking these medications? YES NO  
If no, please explain: \_\_\_\_\_

Does the individual have any mental health diagnosis? YES NO  
If yes, please explain: \_\_\_\_\_

Does the individual have any physical health needs? YES NO  
If yes, please elaborate: \_\_\_\_\_

Have any new medications been prescribed while in your care? YES NO  
If yes, what medications and what do they treat? \_\_\_\_\_

☐ Med list is attached.

Any other special instructions or information about this individual that should be shared (use additional paper if needed):

Substance Abuse History:

Does this individual have any alcohol and/or substance abuse issues/concerns? YES NO  
If yes, please list any/all substance(s): \_\_\_\_\_

How long have they used alcohol and/or substance(s)? \_\_\_\_\_

How often were alcohol and/or substance(s) used? \_\_\_\_\_

When was the last time the individual used alcohol/substance(s)? \_\_\_\_\_

Has this individual used inpatient services for substance abuse? YES NO

If yes, please list when and where the treatment was completed:

\_\_\_\_\_  
\_\_\_\_\_

Please email completed form to [julie.booze@lifehousene.org](mailto:julie.booze@lifehousene.org)

**After reviewing the referral, Care Corps LifeHouse will call the number listed on page one with any follow-up questions. The completed referral form will then be returned via email. If bed space is available and your client is approved, they must arrive at the shelter within 48 hours. After that period, a bed cannot be guaranteed.**

☐ We have appropriate bed space available and will hold a bed for \_\_\_\_\_ up to 48 hours.

☐ We do not have appropriate bed space available at this time.

\_\_\_\_\_  
Care Corps LifeHouse Staff

\_\_\_\_\_  
Date