Habilitation and Respite Referral Form

Please download and complete this form and email it to HOPE Group's Referral Department at: referrals@hopegroupaz.com

Date Completed:			
Client Name:		**Diagnoses:**	
Date of Birth:		**Gender:**	☐ Male ☐ Female
Full Address:			
Name of Parent(s)/ Legal Guardian(s):			
Contact Email:		**Contact Phone Number:**	
Split Home (parents/ guardians live in separate homes):	☐ Yes ☐ No	**Primary Language/Cultural Consideration(s):**	

Support Coordinator:	Name: Email: Direct Phone Number:	
Service(s) Needed:	☐ Habilitation Hours approved weekly:	☐ Respite Hours approved annually:
Provider:	☐ I have a HAH/RSP provider in mind	☐ I need HOPE Group to provide HAH/RSP staff

Basic Health Information:	Is client visually impaired? Is client hearing impaired? Is client physically impaired?	☐ Yes ☐ Yes ☐ Yes	☐ No ☐ No ☐ No	If so, explain: If so, explain: If so, explain:
Allergies:				
Medications as of: **INSERT DATE**	**Medication/Supplement Name**	**Dosage**	**Frequency/Schedule**	
Infectious Disease:	☐ Yes Explain: ☐ No			
Hospitalization, Operations, Other Medical Conditions:	☐ Yes Explain: ☐ No			
History of Seizures:	☐ Yes Explain: ☐ No			
Dietary Restrictions:				
Dietary Considerations:	☐ Food Selectivity ☐ Food Refusal ☐ G-Tube ☐ Requires supplemental nutrition (i.e., PediaSure)			
Adaptive Devices:	☐ Augmentative and Alternative Communication (AAC) Device ☐ Ankle Foot Orthotics (AFOs)/Leg, foot or ankle braces	☐ Glasses ☐ Hearing Aids ☐ Wheel chair/walker/forearm crutches ☐ Other:		

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Communication:

How does your child currently communicate?	☐ Assistive communication device ☐ Gesture ☐ PECS	☐ Sign language ☐ Verbal (estimate # words): ☐ Other:

Social and Play Skills:

How does your child currently interact with peers:	☐ Alone ☐ Parallel Play ☐ Engage with others

Safety:

Has the client worked on safety skills?	☐ Yes ☐ No If "Yes," please explain: Details Here

Gross and Fine Motor:

Are there any moving or lifting concerns that the provider needs to be aware of?	☐ Yes ☐ No If "Yes," please explain: Details Here

Daily Living Skills:

Dressing	Bathing and Grooming	Feeding	Toileting
☐ Undresses ☐ Dresses ☐ Puts on coat ☐ Puts on socks ☐ Puts on pants ☐ Buckles and unbuckles most buckles ☐ Zips and unzips front zippers ☐ Buttons and unbuttons front buttons ☐ Snaps and unsnaps front snaps ☐ Attempts to lace shoes ☐ Puts on shoes ☐ Attempts to tie shoes ☐ Hangs up own clothes on a hook ☐ Hangs up own clothes on a hanger ☐ Folds own clothes ☐ Puts clothes in drawer	☐ Wipes nose with a tissue and puts it in the trash ☐ Uses a washcloth and soap when bathing ☐ Washes hair ☐ Brushes teeth ☐ Flosses teeth ☐ Washes hands ☐ Washes face ☐ Dries both face and hands ☐ Hangs up towel after washing ☐ Brushes hair	☐ Uses side of fork to cut softer foods ☐ Uses a knife for spreading ☐ Uses a knife for cutting ☐ Keeps eating area reasonably clean while eating ☐ Unwraps most food packaging ☐ Opens milk or juice container ☐ Pours liquids into a cup or bowl (from a small pitcher or lunch thermos) ☐ Helps to prepare simple foods (spreading, stirring, using cookie cutters, holding a beater, measuring ingredients, pouring ingredients) ☐ Helps to set the table for meals ☐ Takes dishes to the sink ☐ Wipes the table with a sponge or dish towel	☐ Aims into toilet standing (boys) ☐ Wipes self (girls wipe from front to back) ☐ Zips front zippers ☐ Buttons front buttons ☐ Snaps front snaps ☐ Washes and dries hands - as part of the toileting routine ☐ Night-time trained

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Behavioral Concerns:	☐ Stress/Anxiety ☐ Hair Pulling ☐ Biting ☐ Kicking ☐ Hitting ☐ Elopement/Running away ☐ Inappropriate Touch ☐ Self-Injury	☐ Pica ☐ Property Destruction ☐ Head Banging/Head Butting ☐ Verbal Aggression ☐ Pinching ☐ Scratching ☐ Food Selectivity/Refusal ☐ Inappropriate Sexualized Behavior
Top 3 Areas of Concern:	☐ Gross/Fine Motor ☐ Independent Play ☐ Self-Help Skills ☐ Behavior Reduction ☐ Feeding ☐ Communication ☐ Social Skills	☐ Toileting ☐ Grooming ☐ Routine ☐ Dressing ☐ Other:

Availability for Habilitation Services:

Time	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
7:00 am	☐	☐	☐	☐	☐	☐	☐
8:00 am	☐	☐	☐	☐	☐	☐	☐
9:00 am	☐	☐	☐	☐	☐	☐	☐
10:00 am	☐	☐	☐	☐	☐	☐	☐
11:00 am	☐	☐	☐	☐	☐	☐	☐
12:00pm	☐	☐	☐	☐	☐	☐	☐
1:00 pm	☐	☐	☐	☐	☐	☐	☐
2:00 pm	☐	☐	☐	☐	☐	☐	☐
3:00 pm	☐	☐	☐	☐	☐	☐	☐
4:00 pm	☐	☐	☐	☐	☐	☐	☐
5:00 pm	☐	☐	☐	☐	☐	☐	☐
6:00 pm	☐	☐	☐	☐	☐	☐	☐
7:00 pm	☐	☐	☐	☐	☐	☐	☐

Availability for Respite Services:

Time	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
7:00 am	☐	☐	☐	☐	☐	☐	☐
8:00 am	☐	☐	☐	☐	☐	☐	☐
9:00 am	☐	☐	☐	☐	☐	☐	☐
10:00 am	☐	☐	☐	☐	☐	☐	☐
11:00 am	☐	☐	☐	☐	☐	☐	☐
12:00pm	☐	☐	☐	☐	☐	☐	☐
1:00 pm	☐	☐	☐	☐	☐	☐	☐
2:00 pm	☐	☐	☐	☐	☐	☐	☐
3:00 pm	☐	☐	☐	☐	☐	☐	☐
4:00 pm	☐	☐	☐	☐	☐	☐	☐
5:00 pm	☐	☐	☐	☐	☐	☐	☐
6:00 pm	☐	☐	☐	☐	☐	☐	☐
7:00 pm	☐	☐	☐	☐	☐	☐	☐

If services are needed past 7:00pm, please explain:	

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Provider Preference:	☐ Male ☐ Female ☐ No Preference	**Is a provider needed who can help with dispensing medication?**	☐ Yes ☐ No

Do you need a provider to transport the client?	☐ Yes ☐ No	**If yes, please explain:**	