W-10
(Rev 02/23)

STATE OF CONNECTICUT
Department of Social Services
INTER-AGENCY PATIENT REFERRAL REPORT

PREFERRED NAME (Last, First, Middle)	LEGAL NAME (Last, First, Middle)	BIRTH DATE	ADMISSION DATE	DISCHARGE DATE

CODE STATUS	RELIGION

PREFERRED PRONOUNS	Assigned Sex at Birth
☐ He/Him/His ☐ She/Her/ Hers ☐ They/Them/Theirs ☐ Other (pls specify) _____	☐ Female ☐ Male ☐ Other (pls specify) _____ ☐ Decline to Answer Transgender ☐ Yes ☐ No

CURRENT GENDER IDENTITY	SEXUAL ORIENTATION How does individual identify?
☐ Male ☐ Female ☐ Female-to-Male (FTM)/Transgender Male/Trans Man ☐ Male-to-Female (MTF)/Transgender Female/Trans Woman ☐ Genderqueer, neither exclusively male nor female ☐ Additional Gender Category/other (pls specify) _____ ☐ Decline to answer	☐ Lesbian ☐ Gay ☐ Homosexual ☐ Heterosexual ☐ Bisexual ☐ Don't know ☐ Other (pls specify) _____ ☐ Decline to answer

RACE and/or ETHNICITY	PREFERRED LANGUAGE

HOME ADDRESS (Number, Street, Town or City, State, Zip Code)	PRIMARY PHONE #	MARITAL STATUS

MAILING ADDRESS (Number, Street, Town or City, State, Zip Code)
☐ Same as home address

RESIDENT REPRESENTATIVE
Name _____
Address_____ Phone_____

Any legal authority: Power of Attorney ____ Conservator of Person____ Conservator of Estate____
Authority verified: Yes____ No____

Agency authorized to make decisions_____ Agency Representative_____

REFERRED BY (Name and Address of Facility or Agency)	CONTACT PERSON OR UNIT	PHONE #

REFERRED TO (Name and Address of Facility or Agency)	CONTACT PERSON OR UNIT	PHONE #

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FOLLOW-UP BY (Name and Address of Provider or Clinic) 1. ----------	PHONE # ----------	DATE OF NEXT APPOINTMENT ----------
FOLLOW-UP BY (Name and Address of Provider or Clinic) 2. ----------	PHONE # ----------	DATE OF NEXT APPOINTMENT ----------

MEDICAL RECORD #	MEDICARE #	MEDICAID #	OTHER INSURANCE

PERTINENT HISTORY (diagnosis, mental and behavioral health history, surgical history) and PLAN OF CARE (include treatment, diet, activity permitted)

Vital Signs

VACCINATIONS

ALLERGIES

MEDICATIONS (Drug, Strength, Mode)	FREQUENCY	LAST GIVEN	MEDICATIONS (Drug, Strength, Mode)	FREQUENCY	LAST GIVEN
1.			6.		
2.			7.		
3.			8.		
4.			9.		
5.			10.		

SPECIAL PREFERENCES	DIAGNOSIS GIVEN EXPLAINED TO ☐ Individual ☐ Family ☐ Other (specify)	PROGNOSIS EXPLAINED TO ☐ Individual ☐ Family ☐ Others (specify)

IS THE INDIVIDUAL HOMEBOUND? ☐ Yes ☐ No

INDIVIDUAL'S NAME _____

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SERVICES START DATE	☐ Nursing ☐ PT ☐ OT ☐ ST ☐ HH Aide ☐ Social Work ☐ Other		
I HEREBY CERTIFY THAT THE ABOVE SERVICES SHOULD BE PROVIDED BY ☐ Acute Care Hosp ☐ LTACH ☐ CDH ☐ SNF ☐ Rehab Center ☐ HH Agency ☐ ICF/IID ☐ Other (pls specify)			
Provider's Name and Title		Signature	Date Signed

Please use this page for any other pertinent information and additional individual preferences.