



Attendant Care Service Referral/Request Form

<p>Email _____</p> <p>Fax # _____</p> <p>Date _____</p> <p><input type="checkbox"/> Include most recent Inter RAI Assessment</p> <p><input type="checkbox"/> Is Inter RAI Assessment Available on IAR</p>	<ul style="list-style-type: none"> • transferring <p>Be able to direct own care by communicating:</p> <ul style="list-style-type: none"> • their individual needs • time requested for assistance • how assistance is to be provided • have all medical & professional needs met by the existing community health care network on a visitation basis (<i>e.g. Social Work, Nursing, Physiotherapy, etc.</i>)
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FOR ILS OFFICE USE ONLY

<p>ACCEPTS REFERRAL: YES <input type="checkbox"/></p> <p>NO <input type="checkbox"/></p>	<p>Reason for ineligibility :</p> <p>_____</p> <p>_____</p> <p>_____</p>
<p>ASSESSOR NAME: _____</p>	<p>SIGNATURE: _____</p> <p>DATE: _____</p>