Waisman WIN: Wellness Inclusion Nursing Program

University of Wisconsin – Madison
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Phone: (608) 265-9440 Fax: (608) 263-4681

Waisman WIN Referral Request Form

mm/dd/yyyy

Date: _____

Consumer's Name: _____
Last First M.I.

Address: _____
Street City Zip

Telephone #: (___) _____ DOB: ___/___/___ Age: _____ Gender: ☐ Male ☐ Female

Family Contact: _____ Relationship to Consumer: _____

Phone: _____ Cell: _____ Email: _____

Identifying Information

SS #: _____ M.A. #: _____ Medicare #: _____

Private Insurance Carrier: _____ Subscriber I.D. #: _____

Characteristic Code:_____ Diagnostic Code: _____

Dane Co. ACS#: _____ CIP Waiver: ☐ Yes ☐ No

Legal Information

Power of Attorney (POA) for Healthcare: ☐ Yes ☐ No *If yes, please forward copy of POA to this office*.

POA Activated: ☐ Yes ☐ No Date of activation: _____

If *yes*, POA's Name: _____ Relationship: _____

Phone: _____ Email: _____

Legal Guardian: ☐ Yes ☐ No If *yes*, Guardian's Name: _____

Relationship: _____ Phone: _____ Email: _____

Living Will on File: ☐ Yes ☐ No *If yes, please forward copy of the Living Will to this office*.

Service Information

Support Broker: _____ Phone: _____ Email: _____

Residential Provider: _____ Phone: _____ Email: _____

Res. Case Mgr: _____ Phone: _____ Cell: _____ Email: _____

Type of residential support provided: ☐ Live-in ☐ Overnight-sleep ☐ Overnight-awake ☐ Hourly

If hourly, how many hours per day? _____

Please describe situation: _____

Housemate(s): _____

Vocational Provider: _____ Contact: _____ Phone: _____ Cell:_____

Type of work or meaningful activity this person performs? _____

Work Schedule: _____ Where is work performed? _____

Does this person receive **MAPC** hours? ☐ Yes ☐ No If yes, how many per week? _____

MAPC assistance given for what tasks?

_____

Other, please describe (i.e. Home Health nursing, physical therapy, massage therapy, etc)

_____

_____

Consumer Information

Height: _____ Weight: _____ Allergies: _____

Primary Diagnosis: _____

Other: _____

_____

_____

Please describe consumer's favorite activities or interest:

_____

Capabilities **(Please check all boxes that apply)**

a. *Mobility*: Consumer ambulates independently? ☐ Yes ☐ No

Consumer uses: ☐ Manual wheelchair ☐ Electric wheelchair ☐ Walker ☐ Cane

☐ Other (please describe): _____

Transfers: ☐ Independently ☐ Pivot w/assist ☐ Mechanical lift

Comments (i.e. type of lift, description of transfer): _____

b. C*ommunication*: Understands Speech ☐ Yes ☐ No Comments: _____

Speaks: ☐ Yes ☐ No ☐ Conversational ☐ Limited speech ☐ Vocalizations

Comments: _____

☐ Non-Verbal ☐ Eye Blinks ☐ Gestures ☐ Manual Signing

☐ Communication board ☐ Communication Device

☐ Other/Comments

_____

_____

Able to read: ☐ Yes ☐ No Comments: _____

English is secondary language: ☐ Yes ☐ No Comments: _____

c. *Sensory Impairments*: ☐ Partially deaf ☐ Deaf ☐ Visually impaired ☐ Blind ☐ Color blind

☐ Tactile defensive / please explain: _____

Sensory aids used: ☐ Hearing aid ☐ Right ear ☐ Left ear ☐ Glasses ☐ Contacts

☐ Other (describe): _____

d. *Behaviors*: Is this person seen by **Waisman TIES** staff? ☐ Yes ☐ No If yes, whom? _____

☐ Non-compliance ☐ Self-injurious behaviors ☐ Physical aggression towards others

☐ Destruction of property ☐ Physically resistive to cares ☐ Other, please explain

_____

_____

Please list any other helpful information such as Consumer stress factors, approaches or strategies which WIN nurses could use when interacting with the Consumer:

_____

_____

_____

Medical History and Current Condition

Seizures: ☐ Yes ☐ No *If yes, please forward a copy of Seizure Protocol to this office.*

Past Hx. of seizures: ☐ Yes ☐ No Currently Controlled: ☐ Yes ☐ No

Does Consumer have a Vagus Nerve Stimulator? ☐ Yes ☐ No Is Rectal Diastat prescribed? ☐ Yes ☐ No

Who is the doctor that oversees this consumer's seizure disorder? **Physician Name**: _____

_____ Name of Clinic: _____

Clinic Address: _____
Street City Zip

Telephone #: (____) _____

Please explain seizures in detail (i.e, triggers, frequency, duration, any unique characteristics, describe what is seen):

_____

Diabetes: ☐ Yes ☐ No If *yes*: ☐ Type I ☐ Type II Insulin dependant: ☐ Yes ☐ No

If yes, what Diabetes Clinic in Dane County is the Consumer affiliated with: _____

What times of day are the Consumer's blood sugars checked? _____ Who performs glucose monitoring? (please check all that apply): ☐ Consumer ☐ Personal Care Worker/Residential Staff

☐ Vocational Staff ☐ Home Health ☐ Family

☐ Other (please explain)_____

If consumer is insulin dependant, please describe administration (i.e. consumer draws up and self administers, home health nurse administers once or twice daily, etc

_____

Special feeding needs: ☐ Yes ☐ No If yes, explain i.e. requires setup, must be spoon fed:

Please describe consumer's diet: _____

Gastrostomy information: ☐ PEG ☐ Balloon-type G tube ☐ MIC-KEY ☐ Bolus ☐ Pump

Which clinic oversees g-tube? _____ Recent weight gain/loss: ☐ Yes ☐ No

Bladder Control: ☐ Continent ☐ Incontinent History of urinary tract infections? ☐ Yes ☐ No

Requires catheterization? ☐ Yes ☐ No If yes, explain frequency, who performs the procedure?

_____

Bowel Control: ☐ Continent ☐ Incontinent ☐ Constipation

Comments:_____

Medications:

Name of Pharmacy: _____ Telephone #: (___)_____

Does the consumer administer their own medications? ☐ Yes ☐ No Staff assist? ☐ Yes ☐ No

Please obtain and send a current medication list to the Waisman WIN office.

Physicians, Clinic and Hospital Information

Primary Care Physician Name: _____

Clinic Address: _____
Street City Zip

Telephone #: (___)_____ **Psychiatrist** Name: _____

Clinic Address: _____
Street City Zip

Telephone #: (___)_____ ☐ **Neuro-psychologist** or ☐ **Psychologist** (please check one)

Name: _____ Clinic Address: _____
Street City Zip

Telephone #: (___)_____ *Please list any other physicians and their telephone numbers that are actively involved in the care of the Consumer, such as an endocrinologist, cardiologist, pulmonologist, orthopedist, etc.*

_____

_____

_____

_____

Name of **hospital** consumer utilizes: _____

Has this Consumer been hospitalized in the past year? ☐ Yes ☐ No How many times? _____

Reasons for hospitalizations:

_____

_____

_____

_____

Please feel free to list any significant health changes, surgeries or special information you feel the WIN nurses should be aware of:

_____

_____

_____

_____

_____

_____

Reason for referral:

_____

_____

_____

Best time of day for a nursing visit (Monday – Friday):

_____

Please check if action on this referral is: ☐ Urgent (within 2 -3 days) ☐ Next week OK ☐ Within 1 month

Person completing this form: _____

Relationship to the Consumer: _____

Internal Use Only	Living Will	POA	Seizure Protocol	Medication List
Date Obtained				
Nurse Assigned to Case:				
Date of Initial Visit:				