LAW OFFICE OF RACHEL A. BROOKS
Guardianship / Conservatorship Referral Form

WELCOME!

This optional referral form is for facilities or health care providers who have a patient or resident who may need a guardianship or conservatorship. This form is for your convenience. If you prefer, you may call us directly.

If you are a parent or other family member who is interested in guardianship or conservatorship, please skip this form and call us directly.

If you have questions, please call the office directly at 360-699-5801.

Completion of this form does not, in itself, create an attorney-client relationship.

Don't worry if you don't have all the information requested, but please provide as much information as you can.

Thank you!

YOUR INFORMATION

FACILITY NAME:

YOUR NAME:

YOUR TITLE:

YOUR PHONE NUMBER:

YOUR EMAIL ADDRESS:

PERSON IN NEED OF PROTECTION

FULL NAME:

DATE OF BIRTH:

SOCIAL SECURITY NUMBER:

PREVIOUS RESIDENCE OR FACILITY:

DISCHARGE PLAN, IF ANY:

IS THERE A CURRENT POWER OF ATTORNEY? YES NO

FINANCIAL AGENT:

HEALTH CARE AGENT:

FINANCIAL INFORMATION

SOURCE OF INCOME:

SSA SSDI SSI PENSION UNKNOWN

TOTAL MONTHLY INCOME: $

VALUE OF ASSETS (If known): $

BANKS / FINANCIAL INSTITUTIONS:

IS THERE A BALANCE DUE TO THE FACILITY? NO YES ($)

ADULT PROTECTIVE SERVICES

IF APS IS INVOLVED WITH YOUR PATIENT, PLEASE PROVIDE THE NAME AND CONTACT INFORMATION FOR THE APS INVESTIGATOR:

FOR MEDICAID LONG-TERM CARE CLIENTS

MEDICAID LONG TERM CARE (ACES) NUMBER:

DSHS FINANCIAL & HCS WORKERS:

FOR VETERANS

BRANCH OF SERVICE:

SERVICE NUMBER:

DATE ENTERED:

DATE SEPARATED:

FAMILY & FRIENDS

SPOUSE OR DOMESTIC PARTNER:

SPOUSE PHONE NUMBER:

SPOUSE ADDRESS:

CHILDREN

CHILD	ADDRESS	PHONE NUMBER

ADULT STEP-CHILDREN

STEP-CHILD	ADDRESS	PHONE NUMBER

AGENTS / LAWYERS / PAYEES / TRUSTEES / CAREGIVERS

NAME	ADDRESS	PHONE NUMBER

OTHER FRIENDS AND FAMILY

NAME	ADDRESS	PHONE NUMBER

CURRENT HEALTH INFORMATION

PRIMARY DIAGNOSES (Check all that apply)

- Dementia, Alzheimer's Type Dementia, Other
- Stroke
- Heart Disease
- Kidney / UT Disease
- High Blood Pressure
- Schizophrenia
- Diabetes
- Depression
- Anxiety

Other:

COGNITIVE SCREENING

MOCA SCORE:	DATE:
SLUMS SCORE:	DATE:
MMSE SCORE:	DATE:
BIMS SCORE:	DATE:
OTHER:	DATE:

AREAS OF NEEDED ASSISTANCE (Activities of Daily Living)

Medication Management

Making Medical Appointments

Maintaining Nutrition

Preparing Meals

Transfers or Mobility

Transportation

Bathing or Showering

Other Personal Hygiene

Locating Housing

Managing Money

Applying for Benefits

PROPOSED GUARDIAN OR CONSERVATOR

WHO SHOULD BE THE GUARDIAN (Manage personal decisions?)

This is a lay person professional?

WHO SHOULD BE THE CONSERVATOR (Manage financial decisions?)

This is a lay person professional?

OTHER INFORMATION

Please provide any additional relevant information.

THANK YOU for the referral.

Please provide the following documents with the referral: facesheet, DSHS or nurse assessment, Power of Attorney documents, relevant case notes, cognitive screening

Please fax or email this form to:
ELECTRONIC FAX: 360-699-5802
HARD FAX: 360-993-0154
ENCRYPTED EMAIL: rachel@guardianship-law.com