

**CASE MANAGEMENT REFERRAL INFORMATION
GOODWILL OF THE HEARTLAND**

1441 Blairs Ferry Road NE
CEDAR RAPIDS, IA 52402
(319) 393-1210
FAX: (319)393-8935

Instructions: Complete both sides upon referral to the initial Goodwill service. Submit with documentation of disability and appropriate referral information. Thank you for this referral.

Name: _____ Referral Date: _____
(last) (first) (m.i.)

Address: _____

Home Phone: _____ Work Phone: _____

Social Security # : _____ Date of Birth: _____

Marital Status: _____ Veteran?: _____

County of Legal Settlement: _____

Family Information:

(Name) (Relationship) (Address) (Phone)

(Name) (Relationship) (Address) (Phone)

Living Arrangement/Residential Status:

___ Independent ___ Family/friends ___ Programming: _____

Financial Support (Indicate all current sources and amounts of income): _____

Medical Information

Treating Physician(s): _____

Date of Injury: _____ Cause of Injury: _____

Primary Diagnosis: _____ Secondary Diagnosis: _____

Functional Limitations: _____

Current Medications and Dosages: _____

Services Currently Receiving

Medical: _____

Psychological: _____

Vocational: _____

Chemical Dependency: _____

Financial: _____

Other: _____

Vocational History

Vocational History: ___ Currently working ___ Worked previously, not currently ___ Never worked

Employer _____ Job _____ Dates _____

Employer _____ Job _____ Dates _____

Employer _____ Job _____ Dates _____

Employer _____ Job _____ Dates _____

Valid Driver's License? _____ Current mode of transportation: _____

Educational Background

Educational Information (post secondary, secondary, special ed., GED, etc.) _____

Referral Information

Referring Person: _____ Title: _____

Referring Agency: _____

Address: _____

Phone: _____ Fax: _____

Reasons for Referral:

- | | |
|--|---|
| <input type="checkbox"/> New brain injury | <input type="checkbox"/> Legal issues |
| <input type="checkbox"/> Financial issues | <input type="checkbox"/> Emotional support |
| <input type="checkbox"/> Housing issues | <input type="checkbox"/> Information & referral |
| <input type="checkbox"/> Insurance issues | <input type="checkbox"/> Domestic violence |
| <input type="checkbox"/> Declining health | <input type="checkbox"/> Language/literacy barriers |
| <input type="checkbox"/> Mental health dx | <input type="checkbox"/> New to city/state |
| <input type="checkbox"/> Transportation issues | <input type="checkbox"/> Childcare/parenting needs |
| <input type="checkbox"/> Chemical dependency | <input type="checkbox"/> Sexuality concerns |
| <input type="checkbox"/> ADL needs | <input type="checkbox"/> Vocational needs |
| <input type="checkbox"/> Safety concerns | <input type="checkbox"/> Social/recreational issues |
| <input type="checkbox"/> Family interactions | <input type="checkbox"/> Problem solving/organization |
| <input type="checkbox"/> Social skills needs | <input type="checkbox"/> Other |

Comment on any referral issues which need further explanation: _____

Goodwill Case Manager

Date Received

Referring Person

Date