utah department of
human services

Office of Public Guardian

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PH. 801-538-8255 FAX. 801-538-8243 EMAIL. UTAHOPG@UTAH.GOV

REFERRAL WORKSHEET

SERVICE REQUESTED ☐ Guardianship ☐ Emergency Guardianship

PERSONAL INFORMATION OF PERSON BEING REFERRED

Exact Full Name		
Date of Birth	Race	Marital Status
Social Security #	VA #	
Medicaid #	Medical Insurance	

CURRENT LOCATION OF INDIVIDUAL

Please indicate the individual's current, immediate location. ☐ Facility ☐ Hospital ☐ Own Home
☐ Own
☐ Rent

Facility or Hospital Name (if applicable)				
Street Address	Room #	City	State	Zip
Phone	Alt. Phone, Fax, Cell, E-mail (specify)			
Expected Date of Discharge (if any)	Name and Number of Contact Person			

PERMANENT OR REGULAR RESIDENCE

Please indicate where the individual regularly resides, if different from above.

Facility Name (if applicable)				
Street Address	Room #	City	State	Zip
Phone	Alt. Phone, Fax, Cell, E-mail (specify)			
Dates	Notes Re: this Location			

REFERRAL SOURCE CONTACT INFORMATION

Please supply your name and contact information.

Name, Title	Agency, Office, or Hospital Name			
Street Address	Room #	City	State	Zip
Phone	Alt. Phone, Fax, Cell, E-mail (specify)			

MEDICAL DOCUMENTATION

Medical and Mental Health Professionals Who Have Treated or Evaluated

1	Name, Title	Office or Hospital Name			
	Street Address	Room #	City	State	Zip
	Phone	Alt. Phone, Fax, Cell, E-mail (specify)			
2	Name, Title	Office or Hospital Name			
	Street Address	Room #	City	State	Zip
	Phone	Alt. Phone, Fax, Cell, E-mail (specify)			

Psychological / Psychiatric Evaluation	No	Yes	(Attach Copy)
Physician Letter	No	Yes	(Attach Copy)
Medical History & Physical	No	Yes	(Attach Copy)
Authorization for Release of Information	No	Yes	(Attach Copy)
Other _____	No	Yes	(Attach Copy)

CONTACTS

Persons Having Direct Knowledge of the Incapacities Outlined Above (Case manager, social worker, nurse, physician, family, others)

Name, Title	Agency, Office, or Hospital Name			
Street Address	Room #	City	State	Zip
Phone	Alt. Phone, Fax, Cell, E-mail (specify)			

Name, Title	Agency, Office, or Hospital Name			
Street Address	Room #	City	State	Zip
Phone	Alt. Phone, Fax, Cell, E-mail (specify)			

Name, Title	Agency, Office, or Hospital Name			
Street Address	Room #	City	State	Zip
Phone	Alt. Phone, Fax, Cell, E-mail (specify)			

Supports (Spouse, parents, adult children, co-habitants, nearest relatives, attorneys. Include ALL – even if not involved.

Name	Relationship			
Street Address	Room #	City	State	Zip
Phone	Alt. Phone, Fax, Cell, E-mail (specify)			

Name	Relationship			
Street Address	Room #	City	State	Zip
Phone	Alt. Phone, Fax, Cell, E-mail (specify)			

Name	Relationship			
Street Address	Room #	City	State	Zip
Phone	Alt. Phone, Fax, Cell, E-mail (specify)			

Name	Relationship			
Street Address	Room #	City	State	Zip
Phone	Alt. Phone, Fax, Cell, E-mail (specify)			

GUARDIANSHIP / CRITERIA NARRATIVE

1. Please provide us with a written description of what you expect a guardian to do. Items you may want to include in this narrative are:
    a. Does this person adequately provide for his/her healthcare?
    b. Does this person adequately provide for his/her food, nutrition and shelter?
    c. Does this person adequately provide for his/her clothing or personal hygiene?
    d. Does this person adequately provide for his/her safety and/or other care, without which serious injury is likely to occur?
    e. Is this person experiencing or at risk for abuse, neglect or exploitation?
    f. Has Adult Protective Services been involved with this person?
    g. Is this person able to manage his/her financial resources?
    h. Other relevant information