LOUISIANA DEPARTMENT OF HEALTH
Aging and Adult Services

NURSING FACILITY
MDS 3.0 SECTION Q REFERRAL

Completion of this form is required under federal regulation 42 CFR 483.20, which requires federally certified nursing facilities to complete the Minimum Data Set 3.0 (MDS) assessment for all residents. Nursing facilities are required to make a referral to the local contact agency for any resident who, in response to the MDS Section Q questions, indicates that he/she wishes to talk to someone about returning to the community. When a resident indicates that he or she does not want to talk to someone about the possibility of returning to the community or if the result of the Section Q questions is that a referral is not needed, then this referral is not necessary. **Keep a copy of the referral form in the resident's record.**

I. Resident Being Referred

Date of Referral:_____

Name: _____ DOB: _____ SSN: _____

Gender: **M**☐ **F**☐ Phone Number: _____ Is the resident a Veteran? **Yes**☐ **No**☐

Does resident have family contact? Yes☐ No ☐

If yes, who? _____ Contact Phone Number: _____

Is the resident interdicted*? **Yes**☐ **No**☐ Court ordered to be in a NF? **Yes**☐ **No**☐

*If interdicted, Name of Curator: _____

Curator Phone Number: _____

Is the resident a registered sex offender? **Yes**☐ **No**☐

Does resident have a criminal history? **Yes**☐ **No**☐ **Unknown**☐

II. Nursing Facility Information

Nursing Facility Name: _____

Nursing Facility Parish: _____ Nursing Facility Region: _____

Staff Name: _____ Title: _____

Staff Email: _____Staff Phone Number: _____

Date of admission: _____ # of days since admission: _____

III. Additional Resident Information

Does resident have mental illness noted on Level 1 PASSR or Resident Review? **Yes**☐ **No**☐
If yes, please list diagnoses, medications, and any specialized services:
_____

Does resident have a Level II on file? **Yes**☐ **No**☐

Sources of income with income amount:

1) Source: _____ Income Amount: $ _____
2) Source: _____ Income Amount: $ _____
3) Source: _____ Income Amount: $ _____

Does the resident have available housing to transition to? **Yes**☐ **No**☐

Has the Nursing Facility explored resident's housing options? **Yes**☐ **No**☐

What areas/places would resident be willing to live?

What actions have been taken to locate housing? (i.e., added name to waiting list, etc.)

Housing Comments:

NOTE: Please attach the portion of the resident's Plan Of Care (POC) related to discharge.

PLEASE EMAIL COMPLETED FORM TO THE OFFICE OF AGING AND ADULT SERVICES.

For a list of Local Contact Agencies (LCAs), see the Online Regional Office Directory:

http://ldh.la.gov/index.cfm/directory/category/141