

**NURSING FACILITY  
MDS 3.0 SECTION Q REFERRAL**

1. 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 (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.
2. Keep a copy of the referral form in the resident's medical record.

<b>Date of Referral</b> _____
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**I. Resident Being Referred**

Resident Name: \_\_\_\_\_ Resident DOB: \_\_\_\_\_ Resident SSN: \_\_\_\_\_

Resident Gender: **M**  **F**  Resident Phone Number: \_\_\_\_\_ Is resident a Veteran? **Yes**  **No**

Does resident have family contact? **Yes**  **No**

If yes, who? \_\_\_\_\_ Family Contact Phone Number: \_\_\_\_\_

Is the resident any of the following..?

Interdicted\*? **Yes**  **No**

Court ordered to be in a NF? **Yes**  **No**

\*If interdicted, indicate name of curator: \_\_\_\_\_

Curator Phone Number: \_\_\_\_\_

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

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

**II. Nursing Facility**

Nursing Facility Name: \_\_\_\_\_

Nursing Facility Parish: \_\_\_\_\_ Nursing Facility Region: \_\_\_\_\_

Staff Person Name: \_\_\_\_\_ Staff Person Title: \_\_\_\_\_

Staff Person Email: \_\_\_\_\_ Staff Person Ph. Number: \_\_\_\_\_

Date of admission: \_\_\_\_\_ # of days since admission: \_\_\_\_\_

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**III. Additional Resident Information**

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Does resident have a mental illness noted on the Level 1 PASSR or Resident Review? **Yes**  **No**

If yes, please list diagnoses, medications, and any specialized services: \_\_\_\_\_

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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: \$ \_\_\_\_\_

Is housing needed to transition? **Yes**  **No**

If yes, has the Nursing Facility explored resident's options and where? **Yes**  **No**

What areas/places would resident be willing to live? \_\_\_\_\_

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

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Housing Comments: \_\_\_\_\_

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**NOTE: Please attach the portion of the resident's POC related to discharge.**

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

For a list of local contact agencies, see:

<http://new.dhh.louisiana.gov/assets/docs/OAAS/publications/SectionQ/Reg-Office-Right-Fax.pdf>