Attachment B

FAX REFERRAL

Date: ___________ **Total Pages**: _____________

From: Person and Agency Making Referral____

Agency/Phone Number___________________________________

Do you want to be contacted prior to assessment / regarding outcome of referral? Yes /No
(Circle one) (Circle one)

If marked "yes" a signed Release of Information must be sent with referral.

Concerning: Name ____

Address____

City/zip____ Phone Number____________________

Discharge Date_______________________ DOB _________________________

Social Security __________________________Medicare_________________________

Marital status__________________________ Race_______________________

What services, if any, will client receive through Medicare, Medicaid, or Private Insurance?

____

____

SENIOR CHOICES service(s) requested: Homemaker Personal Care Meals Respite

Adult Day Care Nursing Prescription Assistance Counseling

Insurance Counseling Emergency Response System Medical Transportation

Durable Medical Equipment Chores Caregiver Support Home Repair/Modification

Continuity of Care attached? Yes No

Is this a current **SENIOR CHOICES** client? Yes No

Has patient agreed to referral and proposed plan of care? Yes No

COMMENTS:____

____

____

____

____

PLEASE PRINT ALL INFORMATION