CENTRACARE
Program of All-Inclusive Care for the Elderly (PACE)

## Client/Patient Information

Has the Client/Family been informed of the referral? Yes ☒ No ☐ Date:

| | | | |
|---|---|---|---|
| **First Name:** | **Last Name:** | | Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ |
| **DOB:** | **Age:** | **Sex: M F** | **Phone:** |
| **Address:** | **City:** | | **Zip:** |
| **Residence**: Alone ☐ Spouse ☐ Relative ☐ AFC ☐ | | **County:** | |
| **Insurance Coverage**: Medicaid ☐ Medicare ☐ ☒ Other: ☒ Kellogg Retiree: | | **Language:** English ☐ Spanish ☐ Other ☐ | |

## Caregiver/Contact Information

| | |
|---|---|
| **Name:** dsadf | **Relationship:** |
| **Phone:** | **Assistance Provided by Caregiver:** |

## Medical and Physical Health Needs

**Current Physician:**

Check all that Apply:

- ☐ **Hands on Assist with transferring, feeding, toileting, catheter or ostomy care**
- ☐ **Confusion, dementia, Memory Problems-difficulty managing medications, finances, appointments, or other daily tasks.**
- ☐ **Daily Oxygen use: ☐ with shortness of breath ☐without shortness of breath**
- ☐ **Daily Tracheotomy care**
- ☐ **Dialysis**
- ☐ **End of Life Care**
- ☐ **Chronic ER visits (2 or more visits within a 1 month period with 2 or more new orders)**
- ☐ **Recent Falls**
- ☐ **Uses an assistive device for mobility : Cane☐ Walker ☐ Wheelchair ☐**

**Diagnosis:**

**Current Services in Place**: Homecare RN ☐ PT/OT/ST ☐ Chore Provider ☐
Other:_____

## Referral Information

| | |
|---|---|
| **Contact Name:** | **Agency:** |
| **Phone:** | **Email:** |

**What services are you looking for?**

For more information call Donna or visit our website:269.441.9313 www.mycentracare.com
Fax to Battle Creek: 269-441-3487 Or Kalamazoo: 269-488-3616