Senior Care Partners P.A.C.E.

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:**	**Phone:**

Address:	**City:**	**Zip:**

Residence: Alone ☐ Spouse ☐ Relative ☐ AFC ☐ **County:**

Insurance Coverage: Medicaid ☐ Medicare ☐
☐ Disability ☐ Other:
☐ Kellogg Retiree:

Language: English ☐ Spanish ☐
Other ☐

WHO TO CONTACT

Name/Relation:	**Phone:**
Name/Relation:	**Phone:**

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 ☐**

What Services are you looking for?

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

HOW DID YOU HEAR ABOUT US

Contact Name:	**Agency:**
Phone:	**Email:**

MEDICAL RECORD NUMBER:
APPOINTMENT DATE AND TIME:

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