Senior Care Partners P.A.C.E.

Client/Patient Information

Has the Client/Patient 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 Approved Disability Pending
Other

Language: English □ Spanish □
Other

Additional Contacts

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

Medical and Physical Health Needs

Current Physician: **Affiliation: Bronson Borgess Oaklawn**

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**
- □ **History of Heart disease, Lung disease, or diabetes**
- □ **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 □**

Income Under $2349? No Yes Discuss Private Pay? No Yes

DPOA? No Yes DPOA Name:

Available Documentation:
SS Statement Bank Statement Pension Life Insurance

HOW DID YOU HEAR ABOUT US

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

MEDICAL RECORD NUMBER:
APPOINTMENT DATE AND TIME:

For more information call 269.441.9319 or visit our website: www.SeniorCarePartnersMI.org
Please Fax to Battle Creek: 269-441-3487, Kalamazoo: 269-488-3616, or Portage: 269-280-8990