



# Senior Care Partners P.A.C.E.

Client/Patient Information					
Has the Client/Patient been informed of the referral? Yes <input type="checkbox"/> No <input type="checkbox"/> Date: _____					
First Name:		Last Name:		Single Married Divorced Separated Widowed	
DOB:		Age:	Sex:	Phone:	
Address:			City:		Zip:
Residence: Alone <input type="checkbox"/> Spouse <input type="checkbox"/> Relative <input type="checkbox"/> AFC <input type="checkbox"/>				County:	
Insurance Coverage:		Medicaid Medicare		Language: English <input type="checkbox"/> Spanish <input type="checkbox"/>	
Disability Approved		Disability Pending		Other	
Other					
Additional Contacts					
Name/Relation:				Phone:	
Name/Relation:				Phone:	
Medical and Physical Health Needs					
Current Physician:		Affiliation: Bronson Borgess Oaklawn			
Check all that Apply:					
<input type="checkbox"/> Hands on Assist with transferring, feeding, toileting, catheter or ostomy care					
<input type="checkbox"/> Confusion, dementia, Memory Problems-difficulty managing medications, finances, appointments, or other daily tasks.					
<input type="checkbox"/> Daily Oxygen use: <input type="checkbox"/> with shortness of breath <input type="checkbox"/> without shortness of breath					
<input type="checkbox"/> History of Heart disease, Lung disease, or diabetes					
<input type="checkbox"/> Dialysis					
<input type="checkbox"/> End of Life Care					
<input type="checkbox"/> Chronic ER visits (2 or more visits within a 1 month period with 2 or more new orders)					
<input type="checkbox"/> Recent Falls					
<input type="checkbox"/> Uses an assistive device for mobility : Cane Walker <input type="checkbox"/> Wheelchair <input type="checkbox"/>					
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: <a href="http://www.SeniorCarePartnersMI.org">www.SeniorCarePartnersMI.org</a>					
Please Fax to: 269-441-3487					