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 ☐**

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 269-441-3487