

**AREA OFFICE ON AGING MANUAL REFERRAL FORM**

PASSPORT  LTCC  LOC  Assisted Living

Phone Numbers: 419-382-0624 or 800-472-7277 Complete and Fax to: 419-382-4603

**Consumer Demographics:**

Consumer Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Sex:  M  F Marital Status: \_\_\_\_\_  
 Street Address: \_\_\_\_\_ P.O. Box (if applicable): \_\_\_\_\_ Home Phone: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ County: \_\_\_\_\_  
 Social Security Number: \_\_\_\_\_ Medicare Number: \_\_\_\_\_ Medicaid Number: \_\_\_\_\_  
 Is Client Own Primary Contact?  Yes  No

**Referral Date:** \_\_\_\_\_

**Referral Source:**

Referral Source/Position: \_\_\_\_\_ Organization Name: \_\_\_\_\_ Organization Phone: \_\_\_\_\_  
 Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Emergency Contact**

Emergency Contact/Caregiver: \_\_\_\_\_ Relationship: \_\_\_\_\_ POA:  Yes  No Primary Contact:  Yes  No  
 Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ DOB: \_\_\_\_\_ Last 4 SS#: \_\_\_\_\_

**Reason For Referral:**

**Medical Diagnosis:**

Recent Hospital/N.F. Admission  Yes  No Admission Date: \_\_\_\_\_ Discharge/Expected Discharge Date: \_\_\_\_\_  
 Facility Name: \_\_\_\_\_ Reason for admission: \_\_\_\_\_

**Formal Agency Services:**

Organization: \_\_\_\_\_ Type of Services: \_\_\_\_\_

**Primary Physician:**

Primary Physician: \_\_\_\_\_ Physician Phone: \_\_\_\_\_ Physician Fax: \_\_\_\_\_  
 Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Finances:**

Consumer's Monthly Income: \_\_\_\_\_ Spouse's Monthly Income: \_\_\_\_\_ Assets (Bank Accts, Stocks, Bonds, C.D.'s, Trusts, Cash Value Life Ins, etc.): \_\_\_\_\_

**Activities for Daily Living:**

Please Mark Appropriate Box For: I- Independent S- Supervision H- Hands On Assistance

	I	S	H		I	S	H
Bed Mobility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Medication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Transfer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Shopping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Locomotion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Meal Prep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	House Cleaning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Grooming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Laundry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Toileting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Telephoning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Transportation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Legal/Financial	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>