



Age Wise Program - Referral Form

Referral Date:	Referral Taken By:
Referred By (Agency Name):	
Agency Address:	Phone:

Name:	DOB:	Age:	SSN:
Address:			Phone:
Access Issues (gate code, dog, etc):			

Gender: Male Female **Preferred Language:** English Spanish Other:

Ethnicity: Euro Amer Latino African Amer Asian Amer Native Amer Other:

Monthly Income: _____ SSA SSI Pension General Relief None

Medical Coverage: Medi-Cal Medicare HMO/Supplemental: Private Insurance: (specify) None

Mental Health/ Risk Indicators

Diagnosis:

Visual Hallucination Suicidal Ideation Homicidal Ideation Auditory Hallucination

Other: (specify)

Current/Past Hx of Substance Abuse: Yes No **If Hospitalized, Expected Release Date:**

Medical Conditions/Physical Limitations:

<input type="checkbox"/> Diabetes	<input type="checkbox"/> Pulmonary Problems	<input type="checkbox"/> Hearing Impairment	<input type="checkbox"/> Memory/Cognitive Impairment
<input type="checkbox"/> Stroke	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Speech Impairment	<input type="checkbox"/> Alzheimer's/Dementia
<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Infectious or Contagious Diseases	
Ambulation: <input type="checkbox"/> Good <input type="checkbox"/> Poor <input type="checkbox"/> Wheelchair <input type="checkbox"/> Other:			

Other Pertinent Information:

<input type="checkbox"/> History of Violence	<input type="checkbox"/> Pets	<input type="checkbox"/> IHSS	<input type="checkbox"/> VA	<input type="checkbox"/> Adult Day Health Center	<input type="checkbox"/> Senior Companion
<input type="checkbox"/> Hospice	<input type="checkbox"/> IRC	<input type="checkbox"/> ICLS	<input type="checkbox"/> APS	<input type="checkbox"/> Weapon	<input type="checkbox"/> Past Age Wise Client
<input type="checkbox"/> Hazards:			<input type="checkbox"/> Other:		

Client Needs: Food Housing Medical Care Transportation Legal Assistance

Other: _____

Support System: Family Friends Church Sr. Center Other:

Living Situation: Alone Spouse Family Board & Care Room & Board Homeless Other:

Smoking in Household: Yes No Unknown

Include Reason for Referral/Additional Comments:

***NOTE:** Referents should be informed about their referrals so they know that Age Wise staff will be contacting them.