COMPANION REFERRAL FORM

FROM (your name / organization): ____________

FIRST, PLEASE FAX THIS FORM TO: **(831) 646-2026**

To expedite this referral, please send the following with this form:
Updated face sheet, H&P, recent medical notes, medications list & insurance cards.

THEN, CALL US TO CONFIRM RECEIPT: **(831) 648-7606**

CLIENT INFORMATION

Demographics Sheet Attached ☐ **YES** if No, complete info below:

PATIENT NAME: ____________

STREET/APT: ____________

CITY/State/ZIP: ____________

PHONE: ____________

DOB: ____________ GENDER: ☐ MALE ☐ FEMALE

SSN: ____________ Fall Risk: ☐ Yes ☐ No

Emergency Contact : Name ____________

Relationship____________ Phone ____________

Patient location at time of referral:

☐ SNF ☐ HOSPITAL ☐ HOME ☐ AC/REFC

PHYSICIAN INFORMATION

PHYSICIAN NAME: ____________

PHYSICIAN PHONE: ____________

PHYSICIAN FAX: ____________

DNR: ☐ Yes ☐ No

Diagnosis:

____

____

Mental status

Alert/oriented ☐ Yes ☐ No

Confused ☐ Yes ☐ No

Forgetful ☐ Yes ☐ No

Combative ☐ Yes ☐ No

ACTIVITIES OF DAILY LIVING

Check all that apply

Activities	Minimum assist	Moderate assist	Maximum assist
Feeding			
Bathing			
Transferring			

Incontinent? ☐ Yes ☐ No

Equipment: ☐ Wheelchair ☐ Walker ☐ Cane ☐ Lift ☐ Shower chair

HOME SAFETY

What floor is the client bedroom on? ________

Number of steps to enter the client's home? ________

Is the client a fall risk? ☐ Yes ☐ No

Does the client have a primary caregiver? ☐ Yes ☐ No

Does the client live alone? ☐ Yes ☐ No

Flooring: ☐ Carpet ☐ Hardwood

Service Start Date ____________

22 Lower Ragsdale, Suite B, Monterey, CA 93940
www.goodlifehomecare.com