

# Senior Companion Program – Referral Form

REFERRAL DATE: \_\_\_\_\_

START DATE: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

City: \_\_\_\_\_

Zip: \_\_\_\_\_

DOB: \_\_\_\_\_

Sex:  Male  Female

Marital Status:    S    M    D    W    SEP

Ethnicity:    W    B    NA    H    A

Pets:             Yes             No

Smoker:         Yes             No

Referred By:    Agency Name: \_\_\_\_\_

Case Manager/Phone: \_\_\_\_\_

Convalescent Home Discharge:     Yes             No            Hospital Discharge:     Yes             No

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Housing:     Private Home             Private Apt.             Boarding Home             Trailer  
               Senior/Disabled         Congregate             Public                     Other

Lives:             Alone             w/Spouse             w/Children             w/Relative             w/Non-Rel

**Physical Factors/Limitations:**

Mobility:     Full             Cane             Walker             Wheelchair             Bedridden  
Vision:         Good             Partial             Poor            Hearing:     Good             Partial             Poor  
Mental Alertness:     Alert             Forgetful             Confused             Depressed             Dementia

**Activities of Daily Living: - Can the client perform the following tasks without assistance?**

Dress/Tie Shoes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
Bathing/Washing	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
Move Within House	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
Housecleaning	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
Stair Climbing	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
Going Outside	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
Getting Into Car	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
Walk ½ Mile	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know

**Days & Time Companion Services are needed:**

Monday	Tuesday	Wednesday	Thursday	Friday

**Other Services Received:**

- Home Health Aide Agency: \_\_\_\_\_ Schedule: \_\_\_\_\_
- Nurse Agency: \_\_\_\_\_ Schedule: \_\_\_\_\_
- CCCI Case Manager: \_\_\_\_\_
- DSS – Protect Svc. Case Manager: \_\_\_\_\_
- DSS – Title XIX Case Manager: \_\_\_\_\_
- Family Support: \_\_\_\_\_
- Meals on Wheels  COPE  SRS

Is the client receiving any services from DSS?  Yes  No

If yes, can a provider rate be arranged for Companion Services?  Yes  No

Monthly Family Income: \_\_\_\_\_ Number in Household: \_\_\_\_\_

Directions to Client's Home: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are there stairs inside the home?  Yes  No Outside the home?  Yes  No

Companion is needed to assist with the following activities:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Senior Companion Name: \_\_\_\_\_

Initial Visit Date: \_\_\_\_\_ Weekly Schedule: \_\_\_\_\_

Referral Taken By: \_\_\_\_\_