

Fax this to the Adult Day Services Network of Alameda County, (510) 577-1876.

REFERRAL SOURCE

Name, title, agency:		
Preferred Method for Follow-up:		
<input type="checkbox"/> Phone	<input type="checkbox"/> Fax	<input type="checkbox"/> Email
Relationship to potential adult day participant:		
<input type="checkbox"/> Physician <input type="checkbox"/> Nurse <input type="checkbox"/> Social Worker <input type="checkbox"/> Discharge Planner <input type="checkbox"/> Case Manager <input type="checkbox"/> Other		
Reason for Referral <i>Check all that apply</i>		
<input type="checkbox"/> Caregiver respite	<input type="checkbox"/> Supervision	<input type="checkbox"/> Rehabilitation
<input type="checkbox"/> Personal assistance	<input type="checkbox"/> Psychosocial Support	<input type="checkbox"/> Other
<input type="checkbox"/> Medical Monitoring / Management	<input type="checkbox"/> Socialization / Activities	
Comments:		

CLIENT INFORMATION

Primary Caregiver's Name	Phone
Potential Adult Day Participant's Name	Phone
City of Residence	Age
Alzheimer's Disease or other dementia?	
<input type="checkbox"/> No <input type="checkbox"/> Early to mid-stage <input type="checkbox"/> Mid to late stage <input type="checkbox"/> Unknown	
Incontinent?	
<input type="checkbox"/> No <input type="checkbox"/> Yes:bladder <input type="checkbox"/> Yes: bladder & bowel <input type="checkbox"/> Unknown	
Ambulatory?	
<input type="checkbox"/> Yes <input type="checkbox"/> Cane or walker <input type="checkbox"/> Wheelchair <input type="checkbox"/> Unknown	

NATURE OF REQUEST

<input type="checkbox"/> Contact potential participant
<input type="checkbox"/> Contact primary caregiver
<input type="checkbox"/> Return a recommendation to me