PACENorth
Program of All-Inclusive Care for the Elderly

Client/Patient Information			
Has the Client/ Family been informed of the referral? Yes ☐ No ☐			
First Name:	**Last Name:**	Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐	
DOB:	**Age:**	**Sex: M F**	**Phone:**
Address:		**City:**	**Zip:**
Residence: Alone ☐ Spouse ☐ Relative ☐ AFC ☐		**County:**	
Insurance Coverage: Medicaid ☐ Medicare ☐ Other ☐ _____		**Language:** English ☐ Spanish ☐ Other ☐ _____	

Medical and Physical Health Needs
Current Physician:
Check all that Apply: ☐ **Hands on Assist with transferring, feeding, toileting , catheter or ostomy care** ☐ **Confusion, dementia, Memory Problems** ☐ **Daily Oxygen Use: ☐ with Shortness of Breath ☐ without Shortness of Breath** ☐ **Daily Tracheotomy care** ☐ **Dialysis** ☐ **End of Life Care** ☐ **Chronic ER visits (2 or more visits within a 1-month period with 2 or more new orders)** ☐ **Uses an Assistive Device for mobility ☐ Cane ☐ Walker ☐ Wheelchair**
Diagnosis:_____
Current Services in Place: ☐ Homecare RN ☐ PT/OT/ST ☐ Chore Service ☐ Other_____

Caregiver/Contact Information	
Name:	**Relation:**
Phone:	**Assistance Provided by Caregiver:**

Referral Information	
***Contact Name:**	***Agency:**
***Phone:**	***Email:**
Comments:	

Fax this form to: Intake Coordinator at 231-252-3750

For more information call or visit our website:
231-252-2767 www.pacenorth.org