Initials of person completing form_____

BayPath Elder Services, Inc. PCA Program-CONSUMER REFERRAL

Process can take up to 3 Months

Referral Date:_____Assigned to FST:_____Initial Contact Date:_____HV Date:_____

REFERRAL SOURCE:_____Relationship:_____PHONE NUMBER:_____

Consumer Information: **Is the person aware that a referral is being made:** ☐Yes ☐No

NAME:_____ DOB:_____GENDER:_____

ADDRESS:_____PHONE:_____

CITY:_____ZIP CODE_____ALT PHONE:_____

LIVES WITH:_____LANGUAGE:_____INTERPRETER NEEDED: Yes □ NO □

SSN:_____MH MEMBER ID#:_____

Has to be MH Standard or Commonhealth / attach REVS print out

ADL HANDS ON ASSISTANCE NEEDED: **Transfer** **Bathing** **Dressing** **Med Mgmt** **Toilet** **Eating** **PROM**

PCP:_____Phone:_____Fax:_____

Adress:_____NPI#:_____Seen within yr? Yes□ No □

Contacts Information: **Person to call: _____**

#1 Name:_____Phone:_____

Address:_____Alt Phone:_____

Emergency □ Surrogate □ Guardian □ Interpreter □ Relationship:_____

#2 Name:_____Phone:_____

Address:_____Alt Phone:_____

Emergency □ Surrogate □ Guardian □ Interpreter □ Relationship:_____

OTHER SERVICES: _____

SCO:_____ One Care:_____ VNA:_____ AFC:_____

Home Care Services and Schedule:_____

Will DC upon PCA approval Yes □ No □ If no, services to remain in place:_____

Primary DX _____ ICD-10 Code: _____

Other DX _____

Comments/Other Info:

MD Sum faxed:	MD Sum Received:	RN Assigned:	RN Eval Completed	OT Assigned	OT Completed	Verbal Approval	MD Sig. Received