SOURCEWISE
COMMUNITY RESOURCE SOLUTIONS

Care Management Referral
FAX TO: 855-965-0953

CLIENT: _____
(LAST) (FIRST)

ADDRESS: _____

CITY, ZIP _____

PHONE: _____

DOB: _____ GENDER: _____

MEDI-CAL: _____

ISSUE DATE: _____

SOCIAL SECURITY: _____

MEDICARE: _____

ETHNICITY: _____

MONTHLY INCOME: _____

LANGUAGE(S): _____

NUMBER IN HOUSEHOLD / LIVES WITH:

PHYSICIAN: _____

PHONE: _____

FAX: _____

MEDICAL RECORD NUMBER: _____

HOSPITALIZATION IN LAST 6 MONTHS: YES ☐ NO ☐

HOSPITAL/SNF: _____

ADMIT DATE: _____

DISCHARGE DATE: _____

REFERRAL DATE: _____

Is the client or family aware of the referral? YES ☐ NO ☐

Is client willing to work with a care manager? YES ☐ NO ☐

REFERRED BY:

NAME: _____

AGENCY/RELATIONSHIP: _____

EMAIL: _____

PHONE: _____

PERSON TO CALL FOR APPOINTMENT:

NAME: _____

RELATIONSHIP: _____

PHONE: _____

BEST TIME TO CALL: _____

SECOND PERSON TO CALL FOR APPOINTMENT:

NAME: _____

RELATIONSHIP: _____

PHONE: _____

BEST TIME TO CALL: _____

MAIN MEDICAL PROBLEMS (INCLUDE MENTAL HEALTH):

FUNCTIONAL STATUS:

Does client have problems with?

Cognition or dementia? YES ☐ NO ☐

Bladder incontinence YES ☐ NO ☐ Severity: Mild ☐ Moderate ☐ Severe ☐

Bowel incontinence YES ☐ NO ☐

Ambulation YES ☐ NO ☐ Device: Cane ☐ Walker ☐ Wheelchair ☐

Does the client need help with, have significant difficulty with, or is the client unsafe performing:

Eating	YES ☐	NO ☐	Housework	YES ☐	NO ☐
Dressing	YES ☐	NO ☐	Laundry	YES ☐	NO ☐
Transferring	YES ☐	NO ☐	Shopping/Errands	YES ☐	NO ☐
Bathing	YES ☐	NO ☐	Meal Preparation	YES ☐	NO ☐
Toileting	YES ☐	NO ☐	Transportation	YES ☐	NO ☐
Grooming	YES ☐	NO ☐	Medications	YES ☐	NO ☐
Telephone	YES ☐	NO ☐	Money Management	YES ☐	NO ☐

Additional comments about client's functioning: physical and/or cognitive

SERVICES RECEIVING:

IHSS: ☐ Number of hours: ☐ Has IP: YES ☐ NO ☐

MOW: ☐ APS ☐ Home Health: ☐ Mental Health ☐

CBAS / Adult Day Center:

Who helps or visits client? Describe client's social support:

CASE MANAGEMENT SERVICES REQUESTED:

Transportation ☐	DME / Home Safety ☐	Food / Nutrition ☐	Incontinence Supplies ☐
Respite ☐	Homemaker ☐	Personal Care ☐	Medication Management ☐
Housing ☐	Legal ☐	Socialization ☐	Money Management ☐

Describe need for ongoing case management or add any additional information about the client and his/her needs: