U & F Sons, Inc.

Sahara Asian Elderly Care.

www.saharahomecare.com

Address	Tel	Fax
1210 S Highland Ave, Lombard, IL 60148	Tel: (630) 953-1950	Fax: (630) 953-1951
4836 Main St. Suite 202, Skokie, IL 60077	Tel: (847) 329-8500	Fax: (847) 329-8501
2916 ½W. Devon Ave, Chicago, IL 60659	Tel: (773) 274-1380	Fax: (773) 274-1381
2225 W North Ave. Ste M, Melrose Park, IL 60160	Tel: (708) 344-2273	Fax: (708) 344-2277
1830 W Army Trail Road, Hanover Park, IL 60133	Tel: (630) 372-2475	Fax: (630) 372-2488

REFERRAL FORM FOR CCP HOMECARE PROGRAM

CONSENT TO RELEASE REFERRAL INFORMATION

U&F Sons, Inc./Sahara Asian Elderly Care recognizes that the nature of our services means that much of the information we handle is particularly sensitive. The information we collect will relate primarily to areas of health, community support and the protection of individual and public health and safety. We recognise the essential right of individuals to have their information handled in ways, which they would reasonably expect – protected on the one hand and made accessible to them on the other**. It is the policy of U&F Sons/SAEC to limit the exchange of confidential information concerning service users.**

If the client/guardian is unable to provide signed consent, has verbal consent been given? ❑ Yes ❑ No

I, (client/guardian)____

hereby give consent for the Client of (address) ____________________________________

to provide the all relevant referral information to U & F Sons, Inc. for the purpose to receive CCP services.

Signature: ______________________________ Date: ______ / _______ / ___________

General Information

Last Name: ______________________ First Name: ______________________ Sex: Male/Female

Social Security #: ________ - _____ - ________ Status: Green Card / Citizen / Refuge Country of Birth: ______________

Date Of Birth: _____ / _____ / ________ Age:_________ Language: __________________ Marital Status: __________

Address: ________________________________ Appt #:_________ Township: ______________

City: __________________________ Zip Code: ____________ - _________ County: ____________

Tel: (_____) _______ - ____________ Annual Income: $ _____________ Source of Income: SSI / S.S. / Other /________________

Medicaid : Yes / No/ Applied Client's Type of residence: ❑Single Family House ❑Duplex ❑Condo ❑Townhouse

Does the client currently? ❑Rent ❑Owned ❑Living with ______________________

Emergency Contact

1) Spouse: ____ Cell: (_____) _______ - ____________

2) Last Name: ______________________ First Name: ______________________________

Relationship: ________________ Tel: (_____) _______ - ____________ Cell: (_____) _______ - ____________

Address: ____

2) Last Name: ______________________ First Name: ______________________________

Relationship: ________________ Tel: (_____) _______ - ____________ Cell: (_____) _______ - ____________

Medical Information

Treating Doctor's Name: ____

Treating Doctor's Tel: (_____) _______ - ____________

Diagnosis/Health Problems: ❑ Arthritis ❑ Bed bound ❑ Bowel/Bladder ❑ Cancer ❑ Deaf ❑ Depression
❑ Confused/Dementia ❑ Diabetes ❑ Frequent Falls ❑ High Blood Pressure ❑ Heart Problems ❑ Hard of Hearing
❑ Needs Supervision ❑ Paralysis ❑ Poor Ambulation ❑ Respiratory Problems ❑ Tremors ❑ Wheelchair
❑ Walker/Cane ❑ Seizure/Epilepsy ❑ Stroke Victim/CVA ❑ Visually Impaired/Blind

Describe Medical Condition and list all medications: ____

____

____

Other Information

Is the client in need of an interpreter at the time of assessment? ❑ Yes ❑ No

If so, what language?____

Will the client require the presence of an advocate (independent, family member or friend) at the time of assessment?

❑ Yes ❑ No

If so, please provide their name, relationship to the client and contact details ______________________________

What are the client's current support needs? ❑Using the telephone ❑Shopping ❑Preparing meals ❑Housekeeping
❑Doing laundry ❑Using transportation ❑Maintaining continence ❑Eating ❑Using the toilet ❑Bathing ❑Dressing

____

Does the client have a medical condition requiring treatment? If so, please speci-
fy____

____

ADDITIONAL INFORMATION: ____

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____

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************************ **FOR OFFICE USE ONLY** ************************

Referral Received on: _____/ _____ / __________ Referral Received From: ______________________________

Referred to Dept on: _____/ _____ / __________ Dept Visit (if Available) : _____/ _____ / __________

Remarks: ____

____

____

Case Status on _____/ _____ / __________ : ❑ Approved ❑ Not Approved ❑ Pending

Case Status on _____/ _____ / __________ : ❑ Approved ❑ Not Approved ❑ Pending

Supervisor Name: ____ Location: ___________________________