U & F Sons, Inc.
Sahara Asian Elderly Care.
www.saharahomecare.com

1210 S Highland Ave, Lombard, IL 60148 | Tel: (630) 953-1950 | Fax: (630) 953-1951
5200 Main St. Suite 205, Skokie, IL 60077 | Tel: (847) 329-8500 | Fax: (847) 329-8501
489 W. Boughton Rd, Bolingbrook, IL 60440 | Tel: (630) 679-1580 | Fax: (630) 679-1581
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 specify_____

_____

ADDITIONAL INFORMATION: _____

_____

_____

_____

********** 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: _____