U & F Sons, Inc.

Sahara Home Care

www.saharahomecare.com

510 E. 22nd St, **Lombard**, IL 60148 Tel: (630) 953-1950 Fax: (630) 953-1951

5200 Main Street **Skokie**, IL 60077 Tel: (847) 329-8500 Fax: (847) 329-8501

2900 W.**Devon** Ave. Chicago, IL 60659 Tel: (773) 274-1380 Fax: (773) 274-1381

2225 W. North Ave. **Melrose Park**,IL 60160 Tel: (708) 344-2273 Fax: (708) 344-2277

1830 W.Army Trail Rd. **Hanover Park**, IL 60133 Tel: (630) 372-2475 Fax: 630-372-2488

489 W. Boughton Road **Bolingbrook**, IL 60440 Tel: (630) 679-1580 Fax: (630) 679-1581

8104 S. Roberts Rd. **Justice**, IL 60458 Tel: (708) 594-2273 Fax: (708) 594-2217

1837 Larkin Ave. **Elgin**, IL 60123 Tel: (847) 608-9352 Fax: (847) 608-9353

4310 W. Lawrence Ave. **Chicago**, IL 60630 Tel: (773) 685-2273 Fax: (773) 685-2272

1717 W. Golf Road **Mount Prospect**, IL 60056 Tel: (847) 427-2273 Fax: (847) 640-9204

1024 S McHenry Ave. **Crystal Lake**, IL 60014 Tel: (815) 455-2273 Fax: (815) 455-2278

2502 S Alpine Rd, **Rockford**, IL 61108 Tel: (779) 210-7151 Fax: (779) 210-7157

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

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____

ADDITIONAL INFORMATION: ____

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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: ____________________