

## Options Counseling Referral Form

Please fill out and fax to this #: 781-477-9631. Do not email UNLESS through a secure email system.

| REFERRAL SOURCE INFORMATION                                                 |  |                                                                                                                                                                                |  |
|-----------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| Name of Referring Person:                                                   |  | Referral Date:                                                                                                                                                                 |  |
| Name of Referring Agency/Relationship:                                      |  |                                                                                                                                                                                |  |
| Email:                                                                      |  | Phone:                                                                                                                                                                         |  |
| APPLICANT INFORMATION                                                       |  |                                                                                                                                                                                |  |
| Name:                                                                       |  | Does the Applicant know that a referral is being made on their behalf?<br>Yes      No                                                                                          |  |
| Address:                                                                    |  |                                                                                                                                                                                |  |
| City/Zip:                                                                   |  | Is the Applicant a veteran?<br>Yes      No                                                                                                                                     |  |
| Phone:                                                                      |  | Does the Applicant live alone?<br>Yes      No                                                                                                                                  |  |
| CellPhone:                                                                  |  | If no, who do they live with?<br><br>Housing Type:<br>Subsidized Elder Building      Private Home<br>Subsidized/Private Apt.      Own Home<br>Single Room Occupany      Rental |  |
| Gender:                      M              F              T                |  |                                                                                                                                                                                |  |
| DOB:                                                                        |  |                                                                                                                                                                                |  |
| SSN:                                                                        |  |                                                                                                                                                                                |  |
| Marital Status:              W              M              S              D |  | HEALTH INSURANCE INFORMATION                                                                                                                                                   |  |
| Applicant Primary Language:                                                 |  | Medicare #:                                                                                                                                                                    |  |
| If not English, is an interpreter needed?      Yes      No                  |  | Mass Health #:                                                                                                                                                                 |  |
| Interpreter Name and Relationship:                                          |  | Other Insurance Name/#:                                                                                                                                                        |  |
| Phone:                                                                      |  | PCP/HEALTH PROVIDER INFORMATION                                                                                                                                                |  |
|                                                                             |  | Provider Name:                                                                                                                                                                 |  |
| EMERGENCY CONTACT                                                           |  | Phone:                                                                                                                                                                         |  |
| Name:                                                                       |  | Fax:                                                                                                                                                                           |  |
| Address:                                                                    |  |                                                                                                                                                                                |  |
| City/Zip:                                                                   |  | ALTERNATE / OTHER EMERGENCY CONTACT                                                                                                                                            |  |
| Relationship to Applicant:                                                  |  | Alternate Contact Name:                                                                                                                                                        |  |
| Phone:                                                                      |  | Alternate Contact Phone:                                                                                                                                                       |  |
| Cellphone:                                                                  |  | Relationship to Applicant:                                                                                                                                                     |  |

| <b>DIAGNOSES and REASON FOR REFERRAL</b> <i>(briefly describe the situation)</i>                                                                                                                  |                           |                 |      |                           |         |  |  |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------|-----------------|------|---------------------------|---------|--|--|--|
|                                                                                                                                                                                                   |                           |                 |      |                           |         |  |  |  |
| <b>HOSPITAL OR NURSING FACILITY DISCHARGE</b>                                                                                                                                                     |                           |                 |      |                           |         |  |  |  |
| Was the Applicant discharged from a hospital, nursing facility, or other institution in the past 90 days?                                                                                         | Hospital Name:            |                 |      |                           |         |  |  |  |
| Yes      No                                                                                                                                                                                       | Reason for Admission:     |                 |      |                           |         |  |  |  |
| Was Applicant discharged with Certified Home Health Care/VNA?                                                                                                                                     | Admission Date:           | Discharge Date: |      |                           |         |  |  |  |
| Yes      No                                                                                                                                                                                       | Nursing Facility Name:    |                 |      |                           |         |  |  |  |
| Provider Name:                                                                                                                                                                                    | Reason for Admission:     |                 |      |                           |         |  |  |  |
| List certified services:                                                                                                                                                                          | Admission Date:           | Discharge Date: |      |                           |         |  |  |  |
| <b>Who should be called to set up a visit?</b>                                                                                                                                                    |                           |                 |      |                           |         |  |  |  |
| <table border="1"> <thead> <tr> <th>Name</th> <th>Relationship to Applicant</th> <th>Phone #</th> </tr> </thead> <tbody> <tr> <td colspan="3" style="height: 40px;"></td> </tr> </tbody> </table> |                           |                 | Name | Relationship to Applicant | Phone # |  |  |  |
| Name                                                                                                                                                                                              | Relationship to Applicant | Phone #         |      |                           |         |  |  |  |
|                                                                                                                                                                                                   |                           |                 |      |                           |         |  |  |  |
| <b>COMMENTS</b> <i>Please add any additional important information (animals in the home, safety concerns for workers, etc.) and why Options Counseling is needed.</i>                             |                           |                 |      |                           |         |  |  |  |
|                                                                                                                                                                                                   |                           |                 |      |                           |         |  |  |  |