CASE MANAGEMENT CLIENT REFERRAL FORM

City of Oakland, Adult & Aging Services, Department of Human Services
150 Frank H. Ogawa Plaza, Suite 4340| Oakland, CA 94612 | Main: 510.238.3762 | Fax: 510.238.7696
http://www.oaklandhumanservices.org

Referral Source Information:

Organization: _____ Relationship/ Referral Type: _____ Date: _____

_____ _____
Name, Title Address

_____ _____ ***Is prospective enrollee aware of referral?*** ____ ____
Telephone (Main) Email Yes No

** Please note, all case management programs are a voluntary.*

Client's Name: _____
Last Name *First Name* *Middle Initial*

Date of Birth: _____ Age: _____ Gender: _____ SSN: _____

Medicare/RRB Number: _____ Medi-Cal CIN: _____

Marital Status? ☐Married ☐Single ☐Divorced ☐Widowed ☐Partner Race: _____

Major Language Spoken: _____ Is an Interpreter Needed ☐Yes ☐ No

CLIENT'S ADDRESS:

_____
Street Address

_____
City, State, Zip

_____
Telephone (Home)

_____
Telephone (Cell)

CONTACT PERSON/ AUTHORIZED REPRESENTATIVE:

_____
Name

_____
Street Address

_____
City, State, Zip

_____
Telephone (Home) *Telephone (Cell)*

Lives Alone? ☐Yes ☐No

Household Size: _____ Relationship to Contact Person: _____

PHYSICIAN CONTACT:

_____
Name

_____
Street Address

_____
Telephone (Main) *Telephone (Fax)*

_____
Clinic Name

_____
City, State, Zip Code

_____
Email

Incontinence: ☐No ☐Yes, Bowel ☐ Bladder ☐

Any falls within the last 6 months: ☐No ☐Yes,

Date(s) _____

Impaired Hearing: ☐No ☐Yes *(i.e. Hearing Aids)* _____

Impaired Vision: ☐No ☐Yes *(i.e. Glasses)* _____

Impaired Speech: ☐No ☐Yes, _____

Other Impairments: ☐No ☐Yes _____

Diagnoses		Medication(s)	

Recent Admissions in last 12 months: *(Check all that apply):*

☐ ER, Date(s):_____ ☐ Hospitalizations, Date(s) :_____ ☐ SNF, Date(s) :_____

Reason:_____

Any evidence or indications of abuse, neglect or exploitation: ☐No ☐Yes Type/ Degree: _____

FUNCTIONAL IMPAIRMENT:

ADLs/ IADLs	Assistance Level	Cognitive/ Emotional	Assistance Level
Eating	☐Low ☐ High	*Memory*	☐N/A ☐Low ☐ High
Dressing/ Grooming	☐Low ☐ High	*Orientation (Person/Place/Time)*	☐N/A ☐Low ☐ High
Bathing	☐Low ☐ High	*Judgement*	☐N/A ☐Low ☐ High
Transfer/ Ambulation	☐Low ☐ High	*Confusion*	☐N/A ☐Low ☐ High
Toileting	☐Low ☐ High	*Combative/ Abusive*	☐N/A ☐Low ☐ High
Meal Preparation	☐Low ☐ High	*Social Isolation*	☐N/A ☐Low ☐ High
Housekeeping	☐Low ☐ High	*Withdrawn*	☐N/A ☐Low ☐ High
Finances	☐Low ☐ High	*Wandering*	☐N/A ☐Low ☐ High
Shopping & Errands	☐Low ☐ High	*Anxiety*	☐N/A ☐Low ☐ High
Telephone	☐Low ☐ High	*Depression*	☐N/A ☐Low ☐ High
Medications	☐Low ☐ High	*Delusion*	☐N/A ☐Low ☐ High

CURRENT BENEFITS AND SOCIAL SUPPORT (Check all the apply):

☐ *Health Plan Care Management*	☐ *Meals*	☐ *Home Health*	☐ *MediCal Health Plan:*
☐ *Veteran Benefits*	☐ *CBAS/ ADHC*	☐ *Legal Resources*	☐ *Medicare Health Plan:*
☐ *Behavioral Health Services*	☐ *IHSS*	☐ *Religious/ Spiritual Support*	☐ *Palliative Care/ Hospice Care:*

REASON FOR REFERRAL/ UNADDRESSED NEEDS (Check all that apply):

Caregiver Stress/ Breakdown ☐	*Health & Safety* ☐	*Lack of/ or Insufficient IHSS Hours* ☐	*Transportation Resources* ☐
DME Needs/ Environmental Hazard ☐	*Housing Resources* ☐	*Legal Resources* ☐	*Other* ☐
Money Management ☐	*Incontinence Supplies* ☐	*Counseling & Support Services* ☐	
Food/ Meal Resources ☐	*Substance Abuse* ☐	*Isolation & Social Support* ☐	