FENWICK LANDING SENIOR CARE COMMUNITY
11665 Doolittle Drive, Waldorf, MD 20602
Ph: (301) 638-4100 Fax: (301) 638-0799

REFERRAL FORM

Completing this information in advance, will allow us to better assist you. All information contained on this form will be kept confidential.

Participant's Name:_____ Phone: _____
Address:_____
DOB:_____ Age:_____ Weight:_____ Sex:_____ SSN#:_____
Person making Referral: _____Relationship:_____
Address:_____
Home Phone:_____ Cell Phone: _____ Work Phone: _____
E-mail Address: _____

What service is this individual being referred for? _____Adult Medical Day Care _____Assisted Living

HEALTH CONDITIONS:
_____
_____

PROBLEMS WITH OR HISTORY OF? (check all that apply):
___ Memory Impairment ___ Mental Illness ____Alcohol Abuse
___ Hearing ___ Speech ___ Vision ___ Swallowing ___ Confusion
___ Wandering ___ Anxiety ___ Hostility ___ Risk of Falling ___ Combativeness
___ Other: _____

NEEDS SUPERVISION OR ASSISTANCE WITH? (check all that apply)
___ Toileting ___ Walking ___ Transferring ___ Feeding ___ Dressing ___ Grooming
___ Uses Adaptive Device: ___Cane ___Walker ___Wheelchair ___ Other: _____

Any Dietary Restrictions?_____
Other Special Needs/ Safety Concerns:_____

Physician's Name:_____ Phone: _____ Fax: _____

For adult day care only:
Number of days a week requesting to attend: ___Two ___Three ___Four ___Five
Days of the week preferred: ___Mon ___Tues ___Wed ___Thur ___Fri
Will you need transportation to and from the Center ___ Yes ___ No
Address we would be providing transportation to/from: _____
_____

HOW WILL SERVICES BE PAID?
____ Privately _____ VA (must be approved by VA) _____Medicaid (which is only for low income individuals). Please note: Medicare, which is senior health insurance, does not pay for medical day care or assisted living. Medicaid, which is for individuals with low income and no assets, requires both financial and medical eligibility to qualify.

If the client is on Medicaid, please write his/her Medicaid number here: _____
Has the client been evaluated by a County AERS nurse? _____

How did you hear about us? ___ Internet ____ Our Street Sign ___ Friend ___ Family
____ Community Group ___ Physician ___ Other:_____

_____ _____
Signature Date