Care Coordination Referral Form

Please fill out form completely; missing information may delay process. Thank you!

Referral Source

Date of Referral:	Referred By:	Agency:	Phone:	Email:

Services Requested

Select at least one service

☐ **Care Coordination:**
- Individual 60+ recently hospitalized or suffered from a health crisis
- Have mild to moderate impairment
- Or temporary severe impairment

Caregiver Support:

☐ Primary caregiver, **18 or older**, caring for an adult who is **60 or older**

☐ Primary caregiver, 18 or older, caring for an individual, of any age, diagnosed with **Alzheimer's** or **disease related dementia**

☐ Family caregiver, who is **55 or older**, who is a grandparent or other non-parent relative, with primary care of a **child 18 or younger**

☐ Primary caregiver, who is **55 or older**, caring for a child, or someone with a **disability**, including parents

☐ **Emergency Response System:**
- Individual 60+; homebound and frail

☐ **Medication Screening:**
- Individual 60+; taking multiple medications, including over the counter, herbs, supplement, patch, eye drops

☐ **Other:**

Consumer

Full Name:		Complete Address:	County: <Choose>	Phone:	DOB:
☐ Male ☐ Female ☐ Declined	Lives Alone: ☐ Yes ☐ No	Primary Language:	Recent Hospitalization: ☐ Yes ☐ No Reason for Admission:		
Reason for Referral:					
Name of Physician:		Physician's Number:	Emergency Contact: Phone: Relationship:		

Verbal consent obtained from consumer/caregiver to share information with AAACAP? ☐ Yes ☐ No

Caregiver

***If requesting Caregiver Support services, following information is required**

Full Name:		Complete Address:	County: <Choose>	Phone:	DOB:
☐ Male ☐ Female ☐ Declined	Race/Ethnicity:	Primary Language:	Relationship to Consumer:		

Please fax OR email referrals to the Area Agency on Aging of the Capital Area at: **Fax: 512-916-6042** or ENCRYPTED email: **ccinfo@capcog.org**