Ascension Living

Alexian PACE

REFERRAL

Please provide as much of the requested information as possible.

Date _____

Referring Organization _____

Contact Name _____ Title _____

Phone _____ Fax _____ Email _____

Name of Referral Address _____ D.O.B. _____

City _____

Medicare No. _____ State _____ Zip _____ Phone _____

Physician Name _____ Medicaid ___Yes ___No

_____ Social Security No. _____

Hamilton County Resident?

___Yes ___No Assets ___Yes ___No Mo Income $_____

With whom does the referral live? ___alone ___spouse ___child ___other _____
Relationship

Caregiver / Family Member Name _____

Relationship to Referral _____

Address _____

City _____ State _____ Zip _____

Phone (Home) _____ (Work) _____

Do we contact this person to schedule a home visit? ___Yes ___No

PACE OFFICE USE ONLY: Notes: _____

Caregiver/ Referral Contacted DATE: _____ _____

Home Visit Scheduled ___Yes___No If yes, DATE: _____ _____

If no, REASON: ___Info Only ___Ineligible (___Out of Area ___Age) _____

Recorded By: _____ _____

What assistance does the individual require? (Check all that apply)

☐ Toileting ☐ Transferring ☐ Eating ☐ Walking/WC ☐ Medications / Insulin ☐ Bathing ☐ Incontinence ☐ Other, please describe below

_____

_____

_____

_____

_____

Does the individual have a diagnosis of dementia? ☐ Yes ☐ No

Is the individual confused and/or disoriented? ☐ Yes ☐ No

SIGNATURE OF INDIVIDUAL BEING REFERRED:

I am interested in learning more about Alexian PACE, and request that an Intake Coordinator contact me.

Sign_____ **Date** _____

Ascension Living Alexian PACE
425 Cumberland Street
Chattanooga, Tennessee 37404

423-698-0802 Main Line
423-495-9114 Intake Office
1-800-441-8883 Toll Free

Fax 423-495-0156

PLEASE RETURN THIS FORM BY FAX OR EMAIL TO:

423-495-0156 (Fax)
AHSCNReferrals@ascension.org

If you have questions or need additional information please call
423-495-9114