



# Greater Lynn Senior Services

Tel 781-599-0110 info@glss.net

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

**DIAGNOSES and REASON FOR REFERRAL** *(briefly describe the situation)*

**HOSPITAL OR NURSING FACILITY DISCHARGE**

Was the Consumer discharged from a hospital, nursing facility, or other institution in the past 90 days?  Yes      No	Hospital Name:	
	Reason for Admission:	
Was Consumer discharged with Certified Home Health Care/VNA?  Yes      No	Admission Date:	Discharge Date:
	Nursing Facility Name:	
Provider Name:	Reason for Admission:	
List certified services:	Admission Date:	Discharge Date:

**CHECK ALL SERVICES REQUESTED**

<p>HOME CARE</p> <ul style="list-style-type: none"> <li>Companion</li> <li>Day Program</li> <li>Heavy Chore</li> <li>Home Delivered Meals</li> <li>Homemaking</li> <li>Laundry</li> <li>Personal Care (bathing, dressing, etc.)</li> <li>Personal Emergency Response System</li> <li>Respite</li> <li>Transportation</li> </ul> <p>Title III MOW</p>	<p>MASSHEALTH SCREENING</p> <ul style="list-style-type: none"> <li>Adult Day Health (ADH)</li> <li>Long Term Care (nursing facility)</li> <li>FEW/SCO</li> </ul> <p>OPTIONS COUNSELING</p> <p>INDEPENDENT LIVING CENTER SERVICES</p> <p>FAMILY CAREGIVER SUPPORT PROGRAM</p> <p>GROUP ADULT FOSTER CARE (GAFC)</p> <p>SHINE Counselor</p>
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**COMMENTS** *Please add any additional important information (animals in the home, safety concerns for workers, etc.)*