Thome PACE

2282 Springport Rd. Jackson, MI 49202

Referral Form

CLIENT/PATIENT INFORMATION			
Has the Client/Family been informed of the referral? Yes ☐ No ☐ **Date**:			
First Name:	**Last Name:**		
DOB:	**Sex:**	**Phone:**	
Address:	**City:**	**Zip:**	
County: Jackson ☐ Hillsdale ☐ Lenawee☐	**Power of Attorney/Advanced Directive:** Yes☐ No ☐		
Insurance Coverage: Medicaid ☐ Medicare ☐ Other:	**Hearing Impaired:** Yes☐ No ☐		

WHO TO CONTACT	
Name/Relation:	**Phone:**
Name/Relation:	**Phone:**

MEDICAL AND PHYSICAL HEALTH NEEDS

Check all that Apply:

- ☐ **Hands on Assist with transferring, feeding, toileting, catheter or ostomy care**
- ☐ **Confusion, dementia, Memory Problems-difficulty managing medications, finances, appointments, or other daily tasks.**
- ☐ **Daily Oxygen Use or Dialysis**
- ☐ **Daily Tracheotomy care**
- ☐ **End of Life Care**
- ☐ **Chronic ER visits (2 or more visits within a 1 month period with 2 or more new orders)**
- ☐ **Recent Falls**
- ☐ **Wounds**

REFERRING CONTACT	
Contact Name:	**Agency:**
Phone:	**Email:**
NOTES:	

FAX TO: 517-748-7600

After receiving this form, our Community Relations Department will call **(within 2 – 4 business days)** to share information about the medical and supportive services available through Thome PACE to help individuals remain in their home safely in the community. There is no obligation with our call. Services authorized by PACE are provided at no charge to those who have both Medicare and Medicaid. Participants may be liable for the costs of unauthorized services or for services provided outside of the PACE program agreement.