SEQUOIA
COMPANION CARE

CLIENT CARE REFERRAL FORM

Please complete and fax the following information to (559) 472-3631

CLIENT INFORMATION

Client Name:_____ DOB:_____ Phone:_____

Address:_____ Alternate Phone:_____

LTC Insurance Type:_____ Insurance #:_____

PCP Name:_____ Family Contact Name:_____ Contact #:_____

Assisted Living Community Name/Contact:_____

Additional Information:_____

DIAGNOSIS/MEDICAL CONDITION:

_____

DAYS OF SERVICE: M T W TH F SAT SUN

HOURS OF SERVICE:

GOALS:

NON-MEDICAL SERVICES NEEDED:

	ADL'S		Homemaking		ADDITIONAL SERVICES:
	Showers/ Bed Bath		Meal Preparation		Fall Risk
	Dressing		Light Housekeeping		Safety Measures
	Personal Care/ Grooming		Bedmaking/Linen Changes		Companionship
	Toileting		Transportation- Appointments, Errands		Other (describe):
	Medication Reminders		Pet Care		

COMPANION CARE SERVICES: Assistance with ADL's and other non-medical needs including meal prep, light housekeeping, transportation, companionship, and more.

We will contact your patient directly to explain our services and set up a FREE, no obligation assessment. Companion care is *NOT* covered through health insurance, but we can assist your patient with various payment options including credit card, county services, VA Aid & Attendance, and long term care insurance plans.

*FAX SENT BY:*_____ *DATE:*_____ *TIME:*_____ *PHONE:*_____ *FAX:*_____

QUESTIONS- CONTACT OUR OFFICE 559.472.3627

Rev 1/18