VOLUNTEERS OF AMERICA OREGON

Adult Day Services Referral Form

You may also fill out a referral form online at www.voaor.org

☐ **LAMBERT HOUSE EAST** (MID/EAST COUNTY)
Phone: (503) 760-2075; Fax: (503) 760-2192

☐ **MARIE SMITH CENTER** (N/NE/NW PORTLAND)
Phone: (503) 335-9980; Fax: (503) 335-0993

Client Information:

Name:

Address:

State: Zip:

Home Phone:

DOB: Sex/Gender:

Marital Status:

Religious preference:

Ethnicity:

Functional Limitations/Special Needs: ☐dementia ☐stroke ☐diabetes ☐depression ☐isolation ☐sedentary ☐wanders ☐behavioral issues ☐hard of hearing ☐high blood pressure ☐Other:

Special Diet:

Other special needs: ☐wheelchair ☐walker ☒quad cane ☐cane ☐glasses ☐hearing aide(s)

Allergies:

Primary Physician:

Phone #:

Specialist:

Phone #:

Hospital Preference:

*For INTERNAL use only:

*Tour: _____ *Intake: _____

*First Day:_____ *Days attending: _____

updated 8/23/07

Referral Source:
☐ADS/Medicaid ☐OPI
☐Private Case Manager ☐Providence ElderPlace
☐Hospital Discharge planner ☐Adult Care Home
☐other: _____

Billing Information: ***Please sign and authorize!***

Max. Days Authorized: ☐per week ☐per month

Approval Date:

Name of person authorizing:

Billing Address:

ADS branch/OPI branch:

OPI/Medicaid/ #:

Case Manager:

Phone:

Reason for Requesting Service: ☐respite ☐working caregiver ☐behavioral issues ☐healthcare issues ☐other _____

Caregiver/Primary Contact Information:

Name:

Relation to client:

Address:

State: Zip:

Home Phone:

Work/cell Phone:

Email:

Other contact person:

Relationship to client:

Phone #:

Transportation:
☐Tri-Met Lift ☐Caregiver
☐MTP Cab ☐MTP W/C Van