NW GWEC

AREA AGENCY ON Aging & Disabilities OF SOUTHWEST WASHINGTON

Referral Form

Email or Fax Completed Form to:
SwansBM@dshs.wa.gov OR Fax to 360-696-4905

Date:_____

Provider Name: _____Clinic Name: _____

Contact Phone Number: _____ Email: _____

PATIENT INFORMATION:

Patient Name: _____ DOB: _____ Male/Female/_____

Phone Number: _____ **Speak to:** ☐**Patient** or ☐**Key Learner**

Address: _____

☐ Patient only wants information mailed, no phone calls.

Key Learner (If different from patient): _____ Does key learner live with patient? Yes/No

Relationship: _____ Phone Number: _____ (If primary contact is not patient)

Additional Patient/Key Learner Information:

_____

_____

_____

REASON FOR REFERRAL: (check all that apply)

☐ Help with ADLs	☐ Housing Assistance or ☐ Energy Assistance
☐ Help with IADLs	☐ Food Stamps/Food Bank Resources
☐Alzheimer's/Dementia Resources	☐ Mental Health Resources
☐ Resources for Key Learner/Caregiver Stress	☐ Transportation Information
☐ Transitional Care (short-term coaching for recently hospitalized patients) *signature needed Date of discharge_____	☐ OTHER (explain below)

COMMENTS:

PERMISSION TO RELEASE INFORMATION TO AGENCY ON AGING & DISABILITIES I, do hereby give my permission to release the above information to the Area Agency on Aging & Disabilities of SW WA (AAADSW), Information & Assistance Program, to follow up with services that may assist me in meeting my current needs. I also give permission for AAADSW to follow up with my health care provider, to share information and provide the most comprehensive resources. I understand this does not obligate me to participate in any program and/or services. My authorization can be revoked at any time and there is no charge for this service.

Patient/Other Representative Signature:_____

Patient/Other Representative Printed Name: _____ Date:_____

**patient or other representative signature is required to process referrals for Transitional Care*

AAADSW internal use only

Completed by _____ Date_____ Call ID_____