

REFERRAL INFORMATION

Program: NHCP

****Please fax completed referral sheet to
503-239-5062**

Referral Source

Contact Name: _____ Organization (if applicable): _____

Email: _____ Phone: _____ Fax: _____

Client Contact Information

Name: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

County: _____ DOB: _____ SS#: _____ Gender: _____

Ethnicity/Race: _____ Primary Language: _____

Emergency Contact Name: _____ Emergency Contact Phone: _____

Emergency Contact Name: _____ Emergency Contact Phone: _____

Provider Information

ID: _____ Organization: _____ Phone: _____ Fax: _____

PCP: _____ Organization: _____ Phone: _____ Fax: _____

Other: _____ Organization: _____ Phone: _____ Fax: _____

*If there are additional medical providers please attach their contact information

Nurse: _____ Organization: _____ Phone: _____ Fax: _____

Social Worker: _____ Organization: _____ Phone: _____ Fax: _____

DHS Worker: _____ Organization: _____ Phone: _____ Fax: _____

Other Community Service Providers (i.e.: Housing Case Manager/Outreach worker, Rep. Payee/Money Manager, POA, Guardian):

Name: _____ Agency: _____ Phone: _____ Fax: _____

Name: _____ Agency: _____ Phone: _____ Fax: _____

Insurance Information

***Please attach copies of Insurance Cards (front/back)**

<input type="checkbox"/> Medicaid	Plan Name: _____	Policy Number: _____
<input type="checkbox"/> Medicare	Plan Name: _____	Policy Number: _____
	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D	
<input type="checkbox"/> Kaiser	Plan Name: _____	Member Number: _____
<input type="checkbox"/> Care of Oregon - Advantage or <input type="checkbox"/> Care of Oregon - Healthshare	Plan Name: _____	Member Number: _____

Income Information

Income Source: _____	Monthly Amount: _____
Income Source: _____	Monthly Amount: _____

Client Details

Current Living Arrangements: home/apt. nursing facility (SNIF/ALF/RCF) SRO houseless other

Care Needs: Bathing Dressing Grooming Oral care Toileting Transferring bed/chair Walking Eating
 Managing medications Using the phone and looking up numbers Doing housework Doing laundry Transportation
 Managing finances

HIV/AIDS Dementia/Cognitive Function Unstable Medical Condition Mental Health Substance Use Other

Current Status: _____

Additional Notes: _____

