Council on Aging Referral Form

4551 County Home Road, Greenville, NC 27858; 252-752-1717; www.pittcoa.com

Date: _____ Last 4 Digits Social Security Number: _____

Client Information: *Client must reside in Pitt County and be 55 and older*

Name:	DOB:	Phone:
Address:	City:	Zip Code:
Emergency Contact Name/Phone:	Who Should We Contact? *(Provide contact #):*	
Client Monthly Income:	Property Owned By Client? ☐ Yes	☐ No

Eligibility and Demographic Information for Statistical Reporting:

60+	☐ Yes	☐ No	Anyone else able to assist with home modifications and/or equipment?	☐ Yes	☐ No
Veteran	☐ Yes	☐ No	Gender: ☐ Male	☐ Female	
Lives alone	☐ Yes	☐ No	Race/Ethnicity:		
Receive Medicaid?	☐ Yes	☐ No	Number of falls in the past year:		

Risk Considerations: *Does the client have any of these risk factors?*

☐	Weakness	☐	Vision Impairments	☐	Neuropathy
☐	Dizziness	☐	Dementia	☐	Worry or fear of falling

Has the client been to the emergency room in the past 30 days?	☐ Yes	☐ No
Has the client been admitted to the hospital in the last 30 days? *Date of discharge:*	☐ Yes	☐ No
Is the client able to independently prepare their own meals?	☐ Yes	☐ No
Does the client have someone who can regularly prepare their meals?	☐ Yes	☐ No

Home Health Services: *Is the client currently receiving?* ☐ Occupational Therapy ☐ Physical Therapy

ADLs/IADLs: *Does the client have difficulty completing any of the following?*

☐	Bathing	☐	Dressing	☐	Grooming	☐	Walking
☐	Eating	☐	Toileting	☐	Housekeeping	☐	Going up and/or down stairs

Services Needed:

☐	Food Insecurity	☐	Grab Bars (List Location)
☐	Meals on Wheels Assessment *(60+)*	☐	Transfer Tub Bench
☐	Long Shower Hose	☐	Socialization, Activities
☐	Shower Chair	☐	Nutritional Supplements (Ensure, Glucerna, Nepro)
☐	Raised Toilet Seat w/ Arms ☐ W/out Arms	☐	Information & Referral (Caregiver, Housing, Long Term Care)

Comments/Other:

Referral Source and Employee Name: _____

Phone and E-Mail: _____

Revised 11.1.2021