send completed referrals via secure email to:

Conversation Record for Referrals

PROVIDER INFORMATION

Referring Provider Name _____ Screening Date _____

Title _____ Referral Date _____

Clinic or Site Name _____ Clinic ZIP _____

If follow up is requested, check provider's preferred follow up method:

☐ Email _____ ☐ Phone _____

PATIENT/CAREGIVER INFORMATION

Patient Name _____ DOB _____ Gender _____ ZIP_____

Ethnicity _____ Veteran ☐ Yes ☐ No Lives Alone ☐ Yes ☐ No

Preferred Contact Info (Phone or Email) _____

Primary Language _____ Needs Interpreter ☐ Yes ☐ No

Type of Insurance ☐ Private ☐ Medicaid ☐ Medicare ☐ Dual-Eligible ☐ None

If someone is helping the patient (friend, family, case manager/social worker), complete the following:

Support person _____ Need caregiver resources ☐ Yes ☐ No

Relationship _____ Phone _____

PATIENT CONSENT FOR INFORMATION RELEASE

Patient consents to the use of confidential information about them to plan, provide, and coordinate services, payments, and benefits or for other purposes authorized by law. Patient further grants permission to agencies, providers, or persons to use confidential information and disclose it to each other for these purposes. Information may be shared verbally or electronically, mail, or hand delivery. *Patient has been informed that Community Living Connections will contact them and consents to this contact.*

Staff Witness Name _____ Date _____

Hold your conversation in private; reassure patients about the privacy of information collected and that their decision to participate in this conversation will not impact their ability to receive care.

"We want to make sure that we provide the best care possible, even after you leave our hospital. We'd like to ask you some non-medical questions to better understand you as a person so that we can meet your needs."

SDoH NEEDS (required)

☐ **Transportation**

"In the past year, have you had trouble getting to medical appointments or the pharmacy, or to run errands?"

☐ **Other** *(please explain)*

_____

_____

_____

☐ **Housing**

"What is your housing situation today?"
"Are you worried about losing your housing?"

"In the past year, have you (or your landlord) repaired everything that needed to be fixed?"

☐ **Financial concerns**

"In the past year, have you had difficulty paying for your utilities or medication?"

☐ **Food**

"In the past year, have you ever worried about whether your food would run out before you had the money to buy more?"

OTHER UNMET NEEDS (optional)

☐ **Help with Activities of Daily Living** *(specify below)*

☐ **Help with Instrumental Activities of Daily Living** *(specify below)*

☐ **Health promotion and chronic disease management**

☐ **Alzheimer's Disease and Dementia support**

☐ **Home safety concerns/fall risk**

☐ **Form preparation** *(specify below)*

Other comments _____

_____

Please indicate any other support services patient or caregiver is receiving or has been referred to: _____

_____

_____

HOSPITAL USE ONLY

☐ Unmet needs identified; AAA follow-up requested

☐ Unmet needs identified; AAA follow-up declined

☐ No needs identified

☐ Unable to perform screening *(please explain)*

_____

_____