Nevada Senior Services, Inc.
Care Partner Institute
901 N. Jones Blvd. Las Vegas, NV 89108
Main Line: (702) 364-2273 Toll Free: (844) 850-5113
www.nevadaseniorservices.org

CARE TRANSITIONS REFERRAL FORM

Date: _____

Referral by: _____ **Phone #:**_____

Name of Agency: _____ **Email:** _____

Participant Information

Participant Name: _____
Hospital: _____
Patient Room Number: _____
Diagnosis: _____
Reasons for Admission**:** _____
☐ Check if primary contact

Family Caregiver Information

Family Caregiver (CG) Name: _____
CG Relationship to Patient: _____
CG Home Phone #: _____ CG Cell Phone #: _____
☐ Check if primary contact

Care Transitions Eligibility Criteria

1. Person with **Alzheimer's disease/dementia** is currently hospitalized for **any medical condition**.
   - ➢ Does the patient live alone? ☐ Yes ☐ No
   - ➢ Does the patient have moderate to severe dementia? ☐ Yes ☐ No
   - ➢ Does the patient with I/DD have ADRD or at high risk for dementia? ☐ Yes ☐ No
   - ➢ Does the patient / cg need assistance with behavioral symptoms? ☐ Yes ☐ No
2. Patient lives at home
3. Patient is transitioning home
4. Medicare Fee-for-Service

☐ _____ **Participant meets all criteria for Care Transitions Program**
(Staff initials)

Please fax or email to:
Nevada Senior Services
Care Partner Institute
Fax number: 702-648-1408
Email: ccrc@nevadaseniorservices.org