



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

- 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
- What is the Patient's Insurance?

<input type="checkbox"/> Medicare	<input type="checkbox"/> Medigap
<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D	<input type="checkbox"/> Private Insurance
<input type="checkbox"/> Medicaid	<input type="checkbox"/> Tricare
<input type="checkbox"/> Veterans Benefit	<input type="checkbox"/> No Insurance
<input type="checkbox"/> Other Insurance	
- Destination after Hospitalization: _____

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

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