Meals on Wheels and Senior Outreach Services

HOME SAFETY MODIFICATION REFERRAL FORM

Client Information

Please complete as much of this form as possible.

Client's Name:____________________________________Client Phone:_____________________

Care Giver's Name: _______________________________Care Giver's Phone:_________________

Client's Address:________________________________City_________________Zip___________

Date of Birth: _______________________ Male or Female Marital Status: ________________

Does the Client live alone? YES or NO
Does the Client Own or Rent their home? OWN or RENT Are there any pets in the home?
Income Level(+/-poverty level): ____________________ (monthly income if known)
Is the Client English speaking? YES or NO If no, is there an Interpreter available? YES or NO
Ethnicity*: (Please, circle one*)
African American, Asian, Pacific Islander, Hispanic, White, American Indian/Alaska Native,
Other_______________
Is the Client a Veteran? YES or NO

Reason for referral?
____
Are there any medical conditions we should know about?___________________________________
Has the Client had a fall? YES or NO
If yes, when and where?____
How many falls in the past 6 months?________
Was 911 called after fall? YES or NO
Was a Citizen's Assist necessary by First Responder's? YES or NO
Did the call result in ambulance ride/hospital admission? YES or NO

Is client exercising? YES or NO
Duration & frequency of exercise___________Interest in In-Home Exercise Program? YES or NO

Family Member to contact:___________________________Phone Number:__________________

What other agencies are involved in clients care? *(ex: Home Health, IHSS, unknown)* ___________
Other fall prevention programs available to client: YES or NO

Referral From:______________________________Contact information:____________________

Please FAX your completed form to the Fall Prevention Program@ (925)946-1869.
Questions? Call (925) 937-8311 email abalke@mowsos.org