Ascension Living

Alexian PACE

Referral Form

Please provide as much of the requested information as possible.

Date _____

Referring Organization _____

Contact Name _____ Title _____

Phone _____ Fax _____ Email _____

Name of Referral _____ D.O.B. _____

Street Address _____

City _____ ST _____ ZIP _____ Phone _____

Medicare No. _____ Medicaid Yes ___ No ___

Physician Name _____ Social Security No. _____

Hamilton County Resident? Yes ___ No ___ Assets? Yes ___ No ___ MO Income $_____

With whom does the referral live? Alone ___ Spouse ___ Child ___ Other ___ _____
Relationship

Caregiver / Family Member Name _____

Relationship to Referral _____

Street Address _____

City _____ ST _____ ZIP _____

Phone (Home) _____ (Work) _____

Do we contact this person to schedule a home visit? Yes ___ No ___

PACE OFFICE USE ONLY:

Date Caregiver/ Referral Contacted _____

Home Visit Yes ___ No ___ If yes, date of home visit _____

If no home visit is scheduled, reason Info Only ___ Ineligible ___ Out of Area ___ Age ___

Notes _____

_____

Recorded by _____

What assistance does the individual require? (Check all that apply)

❒ Toileting ❒Transferring ❒Eating ❒Walking/WC ❒Medications / Insulin ❒Bathing

❒ Incontinence ❒Other, please describe below

_____

_____

_____

_____

_____

Does the individual have a diagnosis of dementia? Yes ___ No ___

Is the individual confused and/or disoriented? Yes ___ No ___

Signature of the individual being referred:

I am interested in learning more about Alexian PACE, and request that an Intake Coordinator contact me.

Sign _____ Date _____

Please return this form via fax or email to:

423-495-0156 (Fax)
AHSCNReferrals@ascension.org

If you have questions or need additional information please call
423-495-9114

Ascension Living Alexian PACE
425 Cumberland Street | Chattanooga, Tennessee 37404
Main: 423-698-0802 | Toll free: 1-800-441-8883
Intake: 423-495-9114 | Fax 423-495-0156

ascensionliving.org/alexianpace