SteppingStone Adult Day Health

Referral Form

Please check a box if you have a preferred center, otherwise, please leave the boxes blank.

CENTER : ☐ GOLDEN GATE Fax 415-359-9282 ☐ MABINI Fax 415-882-7390
☐ MISSION CREEK Fax 415-974-6785 ☐ PRESENTATION Fax 415-923-0275

Please fax the Intake Form to our Intake Coordinator, Ray Yang, at 415-974-6785 or contact him at 415-974-6785 ext.23 or ruiyang@steppingstonehealth.org if you have any questions.

Referral Date: ____________________

Client Name ____

Address ____ Phone __________________
Include area code

DOB	Age	Gender M F TG: FTM/MTF	Lives Alone Y N	Relationship Status M W Sep Sgl D
Race W B As Lat Oth	Ethnicity	Language	Translation? Y N	# of living children
Social Security #	Medicare #	Other Health Insurance, ID #		
Medi-Cal #	Issue Date	Vet Admin #		

SSI: Y N Income:_____________ Other: ______________

Primary Physician	Address	Phone #	Fax #
E-mail			
Psychiatrist	Address	Phone #	Fax #
E-mail			

Emergency contacts 1)	Name	Rel	Address	Phone #
E-mail				
Emergency contacts 2)	Name	Rel	Address	Phone #
E-mail				

Reason for referral: ____

Medical Diagnoses: ____

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Does the client use any mobility device? (Please circle) None Cane Walker Wheelchair (Manual / Electric)

Is your client motivated to come to ADHC? Yes____ No_____

Remarks: ____

Referred by: ____ Phone: ___________________
(Name, Title)

Agency: ____

Revised on 08/08/2016