GEORGIA HEALTH SERVICES NETWORK
PHONE: 770-466-7771 • FAX: 770-466-3810
P.O. BOX 2966 LOGANVILLE, GA 30052

Referral Worksheet

Date Ref:_____

Ref By: _____**Company:**_____**Tele:**_____

How did client find out about us? **Internet Yellow Pages Paper Other:**_____

Client Name: _____DOB: _____

Social Security #_____ Medicaid #_____

Current Address:_____

Main Contact Person:_____Relationship_____

Tel #_____ Email: _____

Current Doctor:_____Tele:_____

Area/Counties that client would be interested for PCH: _____

Current Medical Conditions:_____

_____

_____

Current Living Situation/Notes:

_____

_____

Is client Ambulatory Yes____ No____ If no, answer the following questions…

Wheelchair: Yes___ No___ Is client **wheelchair bound** at all times: Yes__ No__

Walker: Yes___ No___ **Cane**: Yes___ No___ **Shower Chair**: Yes___ No___

Income: _____**SSI** _____ or **Regular Social Security**_____

Does client own a home? Yes___ No___ Any assests? Yes___ No___

Is there a Payee for the Client: _____

Is there a Power of Attorney or Legal Guardian for the Client, if so, please get contact information of POA or Legal Guardian:_____

*****GHSN will require a copy of Legal Guardian ship or POA paperwork at the time of placement