The Senior Health and Resource Partnership Project (SHARP)

Referral Form

Joy Pleasants, Care Coordinator
Email: jpleasants@ccsi.org
Phone: 315-435-5600 Ext. 5648 Fax: 315-435-5612

Date: ______________________

Referral Source ________________________

Contact Name/Phone____

Name of Client: ________________________________ Gender: _________

Address: ____

Phone: __________________ Date of Birth: ______________ Marital Status: __________

Race: _________________ Primary Income/Source: ____________________________

Health Insurance Information: ____

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Limited English Proficiency? Y/N: _______ Living Status: Alone_____ With Spouse Only_____

With Relatives_____ With Non-Relatives_____ With Spouse and Others_____

Please Check Any Areas that Apply and Complete Back Page

Substance Use Concerns: Yes _____ No _____

Describe: ____

Mental Health Concerns: Yes _____ No _____

PHQ9: _____ GAD7 _____

Cognitive Decline: Yes _____ No _____

Describe: ____

Hearing/Vision Concerns: Yes _____ No _____

Describe: ____

Chronic Pain: Yes _____ No _____

Describe: ____

Are You Prescribed Opiates: Yes _____ No _____

Aging and Long Term Care Services Needs: Yes _____ No _____

Aging Screen: _____ Person-Centered Screen: _____

Partner's Reason for Referral:

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Possible Barriers to Engagement:

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Onondaga County Department of Adult & Long Term Care Services

421 Montgomery Street, 5th Floor, Syracuse NY 13202

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