CARE Resource Connection RED CROSS Beyond the Fire Referral Form

CLIENT INFORMATION	
Client	
DOB	
Phone	
Address	

OVERVIEW BARRIERS	
Beyond the Fire	**After the Fire Assistance**
Please circle what is needed: Location of Family Home Care Services Financial Barriers Medical Health Concerns Medications Needed Medical Equipment Needed Social/Family Barriers Mental Health Barriers Transportation Barriers	**Please add any additional notes for intake and outreach:**
FIRE DEPARTMENT REFERRAL	

INTAKE RESULTS		
Chronic Health Conditions	Medical Equipment	Lifestyle
ASTHMA OBSEITY CHF COPD DIABETES **OTHER:**	Oxygen CPAP Walker Cane Wheelchair **OTHER:**	Dietary Needs: Food Insecurity: Yes/No Sleep Problems Substance Abuse Domestic Abuse Lives with Family/Alone Pets **OTHER:**

IS THE CLIENT INSURED? INSURANCE COMPANY	
WHAT IS THE CLIENTS TIME & AVAILABILITY FOR REFERRAL CONNECTIONS	
WHAT OTHER SERVICES IS THE CLIENT REQUESTING	
WHO IS THE CLIENTS CAREGIVER OR EMERGENCY CONTACT	
PRIMARY CARE PROVIDER	
SPECIALITY CARE PROVIDER	
PHARMACY	
MEDICATION LIST CURRENT RX	
DRIVES- HAS ACCESS TO APPOINTMENTS	
CASE MANAGER/SOCIAL WORKER CONTACT	
OTHER BARRIERS	
NOTES/ACTIONS	