Self-Help for the Elderly
安老自助處

Senior Escort Program-New Client Referral Form

***Date:** _____ ***Person Completing:** _____ ***Agency:** _____

IDENTIFICATION (Consumer)

*Last Name:		*First Name:		Middle Name:	
*Date of Birth:		Age:		*Weight:	
*Homeless: ☐ Yes ☐ No ☐ Unknown					
If no, please complete the following:					
*Address:		Cross Street:			
*City: SF	*State: CA	*Zip Code:			
*Phone 1:		◯ H ◯ W ◯ Cell ◯ None ◯ Unknown ◯ Other:			
Phone 2:		◯ H ◯ W ◯ Cell ◯ None ◯ Unknown ◯ Other:			

Residence Entry Information:

*Reason for the senior escort service:

*Any potential dangers to the worker meeting client:

*Tips for contacting client:

*Do any of your friends or family members work at Self-Help for the Elderly?

☐ No. ☐ Yes, please provide his/her name and the relationship:

DEMOGRAPHICS

***Gender:**	☐ Male ☐ Female ☐ Unknown	**Transgender:**	☐ Yes ☐ No ☐ Unknown
***Sexual Orientation:**	☐ Heterosexual ☐ Bisexual ☐ Gay ☐ Lesbian ☐ Declined to State ☐ Unknown		
***Ethnicity:**		***Primary Language:**	
Employment Status:	☐ Full-time ☐ Part-time ☐ Retired ☐ Unemployed ☐ Volunteer ☐ Disabled ☐ Unknown		
Relationship Status:	☐ Single (Never Married) ☐ Domestic Partner ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Decline to State ☐ Unknown		
Veteran Status:	☐ Veteran ☐ Spouse ☐ Child ☐ No ☐ Unknown		
***English Fluency:**	☐ Fluent ☐ Limited ☐ Needs Translation ☐ Unknown		

Literacy:	☐ English ☐ Main Language ☐ Both ☐ Not Literate ☐ Unknown
Supervisory District:	
***Lives Alone:**	☐ Yes ☐ No ☐ Decline to State ☐ Unknown
***Receives SSI:**	☐ Yes ☐ No ☐ Unknown
***Low Income:**	☐ Yes ☐ No ☐ Decline to State ☐ Unknown
Functionally Impaired/Frail:	☐ Yes ☐ No ☐ Unknown

CONTACTS INFORMATION

Contact #1: Is this person your emergency contact?				☐ Yes	☐ No
*Contact Type:					
☐ Personal	*Relationship:*				
☐ Medical	*Type of professional:*				
*Last Name:				*First Name:	
Address:					
City:		State:	**CA**	Zip Code:	
Phone 1:		☐ H ☐ W ☐ Cell ☐ None ☐ Unknown ☐ Other:			
Phone 2:		☐ H ☐ W ☐ Cell ☐ None ☐ Unknown ☐ Other:			

Contact #2: Is this person your emergency contact?				☐ Yes	☐ No
*Contact Type:					
☐ Personal	*Relationship:*				
☐ Medical	*Type of professional:*				
*Last Name:				*First Name:	
Address:					
City:		State:		Zip Code:	
Phone 1:		☐ H ☐ W ☐ Cell ☐ None ☐ Unknown ☐ Other:			
Phone 2:		☐ H ☐ W ☐ Cell ☐ None ☐ Unknown ☐ Other:			

***Transfer Mobility:**				
☐ Independent	☐ Supervision	☐ Assistance	☐ Dependent	☐ Unknown
***Toileting:**				
☐ Independent	☐ Supervision	☐ Assistance	☐ Dependent	☐ Unknown
***Ambulating (Walking):**				
☐ Independent	☐ Supervision	☐ Assistance	☐ Dependent	☐ Unknown
***Shopping:**				
☐ Independent	☐ Supervision	☐ Assistance	☐ Dependent	☐ Unknown
***Telephone:**				
☐ Independent	☐ Supervision	☐ Assistance	☐ Dependent	☐ Unknown

*Transportation:				
☐ Independent	☐ Supervision	☐ Assistance	☐ Dependent	☐ Unknown
*Transportation Type:	☐ Muni	☐ SF Paratransit	☐ Drive	☐ Other
Please provide contact information of the person who arranges Transportation.				
Name:		*Relationship:*		
Phone number:				

***Assistive Devices:**

☐ Glasses	☐ Pronged Cane	☐ Manual Wheelchair	☐ Hearing Aid	☐ Crutches
☐ Motorized Wheelchair		☐ Cane	☐ Walker	☐ Motorized
☐ Other:				

***Sensory Skills:**

Vision:	☐ Good	☐ Limited	☐ Legally Blind	☐ Blind	☐ Unknown
Corrective Lenses:	☐ None	☐ Glasses	☐ Other	☐ Unknown	
Hearing:	☐ Good	☐ Limited	☐ Deaf	☐ Unknown	
Hearing Aid:	☐ None	☐ Hearing Aid	☐ Other	☐ Unknown	
Homecare:	IHSS:	☐ Yes	☐ No		
	Care provider:	☐ Yes	☐ No		

*** COVID 19 Screening**

COVID 19 vaccines	☐ Yes	☐ No		
COVID 19 symptoms:	☐ fever/chills	☐ cough	☐ shortness of breath	☐ fatigue
	☐ Other:			

Appointment

*Appointment type:	☐ **doc appt**	☐ **grocery shopping**	☐ **walk**	☐ **laundromat**
	☐ **Other:**			
*** 1) Appointment date and time:** *(mm/dd/yyyy)*	,	**AM/PM -**	**AM/PM**	
Destination Address:				
* City	*State	**CA**	*Zip Code	
Meeting address if other than home:				
* City	*State	**CA**	*Zip Code	
2) Appointment date and time: *(mm/dd/yyyy)*	,	**AM/PM -**	**AM/PM**	
Destination Address:				
City	State	**CA**	Zip Code	
Meeting address if other than home:				
City	State	**CA**	Zip Code	

Addition Note:

PLEASE SUBMIT THE COMPLETED FORM
TO SELF HELP FOR THE ELDERLY-SENIOR ESCORT PROGRAM
Via email to: **SeniorEscort@selfhelpelderly.org**
OR Fax to: **(415) 391-3760**
OR Mail to: **Self-Help for the Elderly-Social Services-Senior Escort Program**
601 Jackson Street, Basement, San Francisco, CA 94133

Reset Print Submit

Note: After you click on the "Submit" button, a new window will jump up. Please select "Yes" and submit your completed form to the assigned email address.