CITY MANAGER'S OFFICE
Health & Wellness

CASE MANAGEMENT REFERRAL FORM

IRVINE CARES

DATE

PARTICIPANT INFORMATION

FIRST NAME	LAST NAME	DATE OF BIRTH	AGE	GENDER

ADDRESS	MARITAL STATUS	VETERAN	LANGUAGE

CITY	ZIP	EMAIL	PHONE

PREFERRED METHOD OF CONTACT	EMERGENCY CONTACT NAME	EMERGENCY CONTACT NUMBER

REFERENT	REFERENT CONTACT	RELATIONSHIP TO PARTICIPANT

REASON FOR REFERRAL

RISK FACTORS (Check all that apply)

- ☐ CAREGIVING
- ☐ EMOTIONAL HEALTH
- ☐ FINANCIAL
- ☐ HEALTH
- ☐ HOUSING
- ☐ HEALTH INSURANCE
- ☐ LEGAL
- ☐ LANGUAGE/CULTURAL
- ☐ NUTRITION
- ☐ SAFETY
- ☐ SOCIALIZATION
- ☐ TRANSPORTATION
- ☐ OTHER _____

LIVING ARRANGEMENT (Select from list or type in)	IS PARTICIANT IRVINE CONNECTED?	IS PARTICIANT AWARE OF REFERRAL?

FOR OFFICE USE ONLY

REFERRAL RECEIVED BY: ☐ E-MAIL ☐ PHONE ☐ WALK-IN DATE: _____

STAFF NAME: _____ REVIEWED BY: _____

STAFF ASSIGNED _____ DATE ASSIGNED _____ DATE CLOSED _____

FORM 06-10 REV 04/26