**GUIDE Program**

987 East Main Street

Center Conway NH 03813

Mount Washington Valley
Adult Day Center

## Referral Information

Person making the referral? Self / Caregiver / Other (please list below)

Name: _____ Phone: _____ Relationship _____

Referral date: _____ Fax # of sending person/agency: _____

## Patient Information

Name: _____ Date of Birth: _____

Home address: _____

Mailing address: _____

Cell phone: (  ) _____ Home phone: (  ) _____

Email address: _____

## Caregiver Information

Name: _____ Phone: (  ) _____

Email address: _____

Caregiver resides with patient? Yes / No

## Provider(s) Information

Primary Care Provider: _____ Phone: (  ) _____

Referring Provider: _____ Phone: (  ) _____

Dementia Diagnosing Provider: _____ Phone: (  ) _____

The patient is aware a GUIDE referral is being made? Yes / No

*Our office identified a patient who may benefit from GUIDE services, whose eligibility is demonstrated by meeting the below GUIDE Program criteria*

The patient has traditional Medicare (A & B) as their primary payer? Yes / No

*If yes,* Medicare #: _____

The patient is not enrolled in Medicare Advantage or another Medicare health plan, PACE, or Hospice? Yes / No

The patient does not reside in a long-term skilled nursing facility? Yes / No

**Fax this completed form to 603-452-0780 or mail to 987 East Main Street, Center Conway NH 03813, Attn: GUIDE**