Valley Adult Day Health Care Center, Inc.

1052 "C" Street • Fresno, CA 93706
(559) 454-0386 • Fax (559) 237-9377 • e-mail vadhcc@sbcglobal.net

REFERRAL TO VADHCC

Date: ________________

Name of Prospective Participant: ____________________________ DOB: __________ Age: _____

Address:________________________________ City: ________________ State: CA Zip: __________

Telephone: (Home): ____________________ (Other): ____________________________________

Gender: ☐Male ☐Female Veteran: Yes ☐ No ☐ CVRC: Yes ☐ No ☐

Medi-Cal: Yes ☐ No ☐ Cal Viva ☐ Anthem ☐ Kaiser ☐

Diagnosis: ____

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CONTACTS:

1. Name: ____________________________Relationship: ________________Phone: ____________
2. Name: ____________________________Relationship: ________________Phone: ____________

PHYSICIAN INFORMATION:

1. Name: __________________________________Phone: __________________Fax: ___________

   Address: ____

Referral Source: ____

Note: ____

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Contact Person & Phone Number for Home Visit: ______________________________________

For additional Information contact:
Edward Saliba, Administrator and/or Carmen Lara, Program Director
(559)-454-0386