PUBLIC ADMINISTRATOR
CONTRA COSTA COUNTY
P.O. Box 2276
Martinez, CA 94553
Phone: (925) 313-7990
Fax: (925) 623-7096
Email: PublicAdministrator@ehsd.cccounty.us

REFERRAL FORM

DATE: _____

DECEDENT INFORMATION

Decedent's Name: (First)_____(Middle)_____ (Last)_____

Home Address: _____ ☐Homeless

Location of Keys to Residence: _____

Date of Birth: _____ Place of Birth: _____

Father's Name: _____ Mother's Name (Maiden):_____

Date of Death: _____ Place of Death: _____

Social Security #: _____ Marital Status: _____ Race: _____

Sex: _____ Veteran: Y / N Branch: _____ Any papers from VA? ☐No ☐Yes _____

Did decedent have a Will/Trust? ☐No ☐Yes If Yes, Executor/Trustee: _____

Did decedent have an Advance Health Care Directive? ☐No ☐Yes If Yes, Agent: _____

Did decedent have a preneed funeral contract: ☐No ☐Yes If Yes, details:_____

Date Admitted to Your Facility: _____ Admitted From (if from SNF, list name, address and phone number): _____

Current Body Location: _____

Provide a brief history of events leading to referral:

_____

_____

_____

_____

NEXT OF KIN – FRIENDS – OTHER CONTACTS

Name: _____ Relationship: _____

Address: _____ Phone: (_____)_____

Name: _____ Relationship: _____

Address: _____ Phone: (_____)_____

PROPERTY

Real Property: □Own □Rent Landlord: _____ Phone: (_____)_____

Vehicle: □No □Yes Year: _____ Make: _____ Model: _____

Location of Vehicle: _____

Is your facility holding any personal property? □No □Yes (if Yes, list details below)

_____

Is there a trust fund with your facility or another facility? □No □Yes (if Yes, list location and amount below)

_____

DOCUMENTATION OF SEARCH FOR NEXT OF KIN (specify who was contacted, when they were contacted, and what they said):

_____

_____

_____

_____

_____

_____

REFERRING PARTY INFORMATION

Facility Name: _____Address:_____

Name:_____Title: _____

Phone:_____Fax: _____