180 Belt Blvd, Richmond, VA 23224 *Effective 4/2018*

Phone: 804-292-3030/Fax: 804-451-5990

Please call and fax this Referral form to the Medical Respite Program for information regarding bed availability. Admissions accepted between 8:00 AM and 4:30 PM, Monday through Friday. All Admission Criteria must be met and ADMISSION CHECKLIST DOCUMENTS must be provided. Please have patient review General Program Information and Expectations.
All Six (6) pages of Referral should be included with other documents when faxed. **Please allow 24 hours for Referral to be reviewed.**

Please note: Patients must be able to ambulate independently with or without assistive device. Appropriate referrals are those whose condition is reasonably expected to improve within 30 days.

Patient Name: ____**DOB:**_____/_____/________**SSN:**_______/_______/______ **Date**: ____/____/______

Is appropriate for SHELTER SYSTEM? ________If No Reason Why: ____

Primary DX (***ACUTE)*** : ____Secondary DX ____

Allergies: ____ Special Diet Needs: ____

Injury- related weight bearing: ❒ Full, all extremities ❒ Other_____________ Distance able to walk __________Able to climb stairs? __________

Patients in wheelchairs considered on case by case basis and must be able to navigate independently from chair to bed or toilet

Wound Care orders with____# of Visits: ____________________________

Hospital Admit Date: ______/_______/________**Discharge:_____/_______/_________ Expected Admit Date to Respite_____/_____/______**

ADMISSION CRITERIA ***Note: This Facility is NOT equipped for IV lines, non-portable oxygen tanks, Chest tubes, or Wound Vacs***

Yes / No

❒ ❒ 18 years of age and older
❒ ❒ Medically stable as verified by physician documentation
❒ ❒ Contagious phase of an infectious disease
❒ ❒ Oriented to person(s) place, time and able to articulate this information
❒ ❒ Independent in Activities of Daily Living and medication administration
❒ ❒ Ability to exit the building with minimal assistance in the event of emergency
❒ ❒ Registered Sex Offender
❒ ❒ Recent history of violent behavior
❒ ❒ Willing to meet with Medical Respite staff and other health care providers as necessary, and comply with recommendations (see General Program Information and Expectation.)

Yes / No

❒ ❒ Homelessness has been verified
❒ ❒ Able to function in a group setting
❒ ❒ Continent
❒ ❒ Recent use of ETOH / Date: _____/_____/______
(Recent use will not affect admission decision)
❒ ❒ Completed Detox (Days) _______ (if applicable)

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❒ ❒ Psychiatrically stable as verified by physician/ psychiatrist statement as applicable
❒ ❒ Mental Health diagnosis is primary (MH or SA will be considered on a case by case basis)
❒ ❒ Displays/history of suicidal or homicidal ideations; or shows gross disorientation or hallucinations

If you have *answered YES* to any of LAST two Mental Health inquiries, please *complete assessment on page 2*.

ADMISSION DOCUMENT CHECKLIST

Y N **(To be included with this Referral Form) *Decision will be delayed if checklist is incomplete.***

❒ ❒ Authorization to Release Confidential Information Form from your Agency signed by Client
❒ ❒ Homeless Verification From (attached to referral form-DPHS Letterhead) (Page 4)
❒ ❒ List of current prescribed medications
❒ ❒ Copy of Physician Discharge Summary / Recent Progress notes **(if Physician Discharge Summary not available)**
❒ ❒ Copy of Psychiatrist Discharge Summary – if applicable
❒ ❒ **Proof of TB test or copy of chest X-ray completed within the last 12 months*****
❒ ❒ Discharge summary(s) from health system(s), at time of arrival or submitted within 48 hours of admission
❒ ❒ Minimum 30-day supply of prescribed medication(s) and/or a 30-day supply of wound care supplies
❒ ❒ Signature Page from Program Information and Expectations brochure signed and included with referral

Referring Contact information:

Name: ___________________________ **Phone #** _____/______-________**Email (required)** _____________________________________

❒ **Bon Secours (Specify facility)** ______________________________ ❒ **VCUHS** ❒ **RBHA** ❒ **HAMHDS** ❒ **VA**

❒ **HCA (Specify facility)** ____________________________ ❒ **Other**____

Mental Health Risk Assessment

Complete ONLY if you answered YES to questions on (page 1) to Mental Health questions

Client Name: ____ Date: ________________

Status of Hospitalization: ❒ TDO ❒ Commitment ❒ Voluntary ❒ Other___________________

Does client have any of the following Symptoms: (Check all that apply)

❒ Suicidal ideations/behavior ❒ Homicidal Ideation/ assaultive threaten behaviors

❒ Psychosis w/ uncontrolled symptoms ❒ Mood instability

❒ Profound functional impairment; confusional state/ dementia w/behavior dyscontrol

❒Substance withdrawal symptoms

During the entire hospital stay has client been on 1:1, Nurse Observation ❒ **Yes** ❒ **No** Restraints? ❒**Yes** ❒**No**

Previous suicide attempt ❒**Yes** ❒**No** Last attempt (date)_______/______/_______

First attempt (if more than once, age(s) ?):____

If yes, method of attempt (s): ____

Substance abuse/dependence ❒**Yes** ❒**No** Last use, (date): ______/_______/_________

Goal oriented, ❒**Yes** ❒**No**

Major medical condition with chronic pain or doubtful prognosis ❒**Yes** ❒**No**

Major interpersonal conflict, ❒**Yes** ❒**No** Recent loss, ❒**Yes** ❒**No**

Availability of firearms ❒**Yes** ❒**No** Current plan for self/other harm, ❒**Yes** ❒**No**

History of Violence or Impulsive self-injury: ____

____

Referring staff signature: ____

Demographic Information

If available:
Patient's Email:____**Telephone:**______________________________

Please complete ALL Sections:

Marital Status:
______ Single
______ Married
______ Divorced
______ Widow
______ Legally Separated

Race:
______ Black or African American
______White
______Native Hawaiian
______ Asian
______American Indian or Alaska Native
______Other Pacific Islander
______Unreported/ Refused to Report
______More than 1 race

Ethnicity:
______ Hispanic or Latino
______ Non-Hispanic

Insurance Status:
______ VCC
______VCC Pending –Date applied___/____/_____
______**Recently lost health benefits**
______**Recently lost a Job**

______Medicaid #______________________________

______Medicare #______________________________

Any Financial & Non-Financial benefits (e.g., employment, SSI/SSDI, retirement, disability)
Type & Amount______________________________$______________ **Food Stamps** $__________

______**No financial or non-financial resources**

Does This Patient have a PCP?__________

If yes PCP Name____PH__________________________________

If NO, patient will need to sign (Page 6) agreement that Daily Planet Health Services will become their PCP if approved for Program

Veteran Status: ❒Yes❒ No *(This will not affect referral decision)*

On parole ❒ Yes ❒ No **On probation** ❒ Yes ❒ No

Community Medical Respite
180 Belt Blvd
Richmond VA 23224

Ph: 804-292-3030 Fax: 804-451-5990

Prior to hospitalization please indicate patient's status:

Please select one:

_____ Living on the streets _____Living with friends/ family **(Temporary**) _____ Living with friends/ family (**Permanent**)

_____Living in a place not for habitation ______Was incarcerated _____ Lost home/ housing

_____ Emergency Shelter _____ Hospital

Homeless Verification Documentation Form

I verify that this patient's status, ____, is homeless, and that this patient is in need of respite care. I am referring this patient to Daily Planet Health Services' Community Medical Respite for short term convalescent services.

____ __________/_________/___________

Referring Source Name Date

____ _________________________________

Referring Source Signature Hospital Name/Organization

ACKNOWLEDGEMENT OF REVIEW OF PROGRAM INFORMATION AND EXPECTATIONS

My signature below indicates that I have reviewed the Program Information and Expectations brochure and am willing to participate in the Medical Respite program.

Client Printed Name: _______________________________

Client Signature: ____Date: ______________

Primary Care Provider Agreement

I,_______________________________ am aware that I do not have a PCP at this time. I am also aware and I agree that if I am approved for the Medical Respite Program, that Daily Planet Health Services will become my PCP once I enter the program.

_________________________________ ________________________

Client Signature Date

____

Hospital/ Organization

________________________________ ________________________

Referring Source Name Date