MEDICAL RESPITE REFERRAL REQUEST FORMS
180 Belt Blvd, Richmond, VA 23224
Fax: 804-451-5990 /Phone: 804-292-3018

Please fax the completed referral form to the number listed above. All Admission Criteria must be met and all ADMISSION CHECKLIST DOCUMENTS must be provided. *All Six (6) pages of Referral should be included with other documents when faxed.* Your referral will be acknowledged upon receipt. Please allow 24 hours for the referral to be reviewed. Admissions are accepted between 8:00 AM and 4:30 PM, Monday through Friday.

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

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

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

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

Allergies: ____ Special Diet Needs: ____

Non-weight bearing in lower extremities ❒ Yes/ ❒ No Distance able to walk __________Able to climb stairs? ❒ Yes/ ❒ No

Home Care agency (if applicable) _______________________phone number_________________________# of Visits: ______________________

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

ADMISSION CRITERIA

Yes / No

❒ ❒ 18 years of age and older
❒ ❒ Medically stable as verified by physician documentation
❒ ❒ Currently employed?
❒ ❒ 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)

****

❒ ❒ Psychiatrically stable as verified by physician/ psychiatrist statement as applicable
❒ ❒ Mental Health diagnosis is primary (MH or SUD 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. PLEASE INCLUDE COPIES WITH THIS REFERRAL FORM

Yes / No ***Decision will be delayed if checklist is incomplete.***

❒ ❒ List of current prescribed medications and post hospitalization follow up appointments
❒ ❒ Healthcare provider Admission Summary / Recent Progress notes
❒ ❒ **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
❒ ❒ **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
❒ ❒ Authorization to Release Confidential Information Form from your Agency signed by patient
❒ ❒ Homeless Verification Form (Page 4)

Referral Source Contact information:

Name: ____________________________ Phone # ________________Email (required) _________________________

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

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

 Effective 1/2019

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

Please complete all sections

Patient's Email (if available): ____Telephone:________________________

Marital Status: ❒ Single ❒ Married ❒ Divorced ❒ Widow ❒ Legally Separated	
Race: ❒ Black or African American ❒ White ❒ Asian ❒ Native Hawaiian ❒ American Indian or Alaska Native ❒ Other Pacific Islander ❒ Unreported/Refuse to report ❒ More than one race	
Ethnicity: ❒ Hispanic or Latino ❒ Non-Hispanic	**Veteran Status:** ❒ Yes ❒ No
On parole? ❒ Yes ❒ No *This will not affect referral decision*	**On probation?** ❒ Yes ❒ No *This will not affect referral decision*

INSURANCE INFORMATION
Check all that apply and please provide a copy of the card if possible

❒ Recently lost health benefits ❒ Recently lost employment ❒ No Insurance	
❒ VCC ❒ Medicaid ❒ Medicare ❒ VA Healthcare ❒ Other	
Insurance Name:	**Insurance #:**

FINANCIAL & NON-FINANCIAL BENEFITS - *Please list monthly household income. Check all that apply.*

$_____ Employment	$_____ Unemployment Benefits	$_____ Food Stamps	$_____ SSI
$_____ Veteran's Benefits	$_____ Child Support/Alimony	$_____ SSDI	$_____ TANF
$_____ Pension/Retirement	$_____ Social Security	$_____ Other (please explain): __________	
Total Household Income: _____________	Number of people in household __________		
❒ No Income *If no income in received, how does the patient provide food and shelter for his/herself?*			

Effective 1/2019

HOMELESS VERIFICATION DOCUMENTATION

Prior to hospitalization please indicate patient's living status. Please select one.

❒ Living on the streets	❒ Living with friends/family (temporary)	❒Living with friends/family (permanent)
❒ Living in a place not meant for habitation	❒ Was incarcerated	❒ Lost home/housing
❒ Emergency Shelter	❒ Hospital	❒ Other ________________________

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

____
Referring Source Name

__________/_________/___________
Date

____
Referring Source Signature

____
Hospital Name/Organization

COMMUNITY MEDICAL RESPITE
PROGRAM INFORMATION & EXPECTATIONS

Daily Planet Health Services (DPHS) Medical Respite is a short-term convalescent shelter for adults with acute medical conditions requiring recuperative care for up to 30 days. The program serves up to 20 individuals at a time, with two (2) clients per room. The program is co-located with DPHS Southside Health Center (SHC.) You may be seen by a primary care medical provider, and are encouraged to accept DPHS as your medical home if you do not have a primary care provider (PCP).

The program provides 3 healthy meals plus snacks daily. Health education and other group opportunities are offered. You will meet with a case manager and develop an individual service plan during your stay to assist you in developing goals for your medical recovery and housing options.

The staff is available to help you during your convalescence. We will do all we can to make your stay at Daily Planet Medical Respite pleasant and productive.

SIGNING IN/OUT
In order to assist your recuperation, we ask that you not leave the facility during the first three (3) days of your stay for any reason other than for medical, supportive service, or other critical appointments. After that time, for safety reasons, you must sign in and out when leaving and returning. For safety reasons, all clients are to be in the facility by 5:30 PM.

MEDICATIONS
In order to assist in your recuperation, Medical Respite staff will assist you when taking medications. **For everyone's safety, all medications are kept in a secure location**.

SMOKING
Medical Respite is a **Smoke Free** program. Smoking is not allowed on the grounds of the facility.

SUBSTANCE USE
For everyone's safety, bringing alcohol, illegal drugs or drug paraphernalia onto the property, including prescribed narcotics that are not reported or turned in to Respite staff, is cause for immediate dismissal. Clients are subject to random urine and/or breathalyzer tests.

No open flames of any kind are allowed inside the building, (i.e. candles, incense, etc.)

A complete set of guidelines are within the Client Handbook, including rights and responsibilities, and will be provided upon admission. Please sign below to indicate that you have reviewed these expectations.

____________________	____________________	__________
Client Signature	*Client Printed Name*	*Date*

Effective 1/2019

PRIMARY CARE PROVIDER INFORMATION

Does this patient have a Primary Care Provider (PCP)? ❒Yes ❒ No

If yes, PCP Name____ Phone #:_______________________________

If no, please complete the primary care provider agreement below.

PRIMARY CARE PROVIDER AGREEMENT

I,_______________________________ do not have a Primary Care Provider (a medical provider responsible for monitoring my overall health) at this time. I am also aware and I agree that if I am accepted for the Medical Respite Program that the Daily Planet will become my Primary Care Provider (PCP) once I enter the program.

___________________________________ _________________________

Client Signature *Date*

____

Hospital/ Organization

__________________________________ _________________________

Referring Source Name *Date*