MEDICAL RESPITE REFERRAL REQUEST FORM

Fax: 804-451-5990 **Phone**: 804-292-3018 **E-mail**: respitemail@dailyplanetva.org

DATE: _____

Thank you for your partnership with Daily Planet Health Services. 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.

Patient/Client Name: _____ **DOB:** _____ **SSN**: _____

ADMISSION CRITERIA

Yes / No

- ❍ ❍ 18 years of age and older
- ❍ ❍ Medically stable as verified by physician documentation
- ❍ ❍ Condition expected to improve within 30 days
- ❍ ❍ Oriented to person, 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
- ❍ ❍ Able to ambulate independently with or without assistive device (patients/clients in wheelchairs considered on case by case basis)
- ❍ ❍ Psychiatrically stable as verified by physician/ psychiatrist statement as applicable
- ❍ ❍ Willing to meet with Medical Respite staff and other health care providers when needed

Yes / No

- ❍ ❍ Homelessness has been verified
- ❍ ❍ Able to function in a group setting
- ❍ ❍ Continent
- ❍ ❍ Recent history of violent behavior (will not admit)
- ❍ ❍ Registered Sex Offender (will not admit)

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MENTAL HEALTH

- ❍ ❍ 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

ADDITIONAL INFORMATION

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_____

Currently employed? ❒ Yes ❒ No

ADMISSION DOCUMENT CHECKLIST - PLEASE INCLUDE COPIES WITH THIS REFERRAL FORM

- ❒ List of current prescribed medications and post hospitalization follow up appointments
- ❒ 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 a 30-day supply of wound care supplies if indicated
- ❒ Authorization to Release Confidential Information Form from your Agency signed by patient/client

REFERRAL SOURCE CONTACT INFORMATION

Name: _____ **Phone #** _____**Email** (required) _____

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

❒ **HCA** (Specify facility) _____ ❒ **Other**_____

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DEMOGRAPHIC INFORMATION

Please complete all sections

Patient/Client's Email (if available): _____Telephone:_____

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
Marital Status: ❒ Single ❒ Married ❒ Divorced ❒ Widowed ❒ Legally Separated	
Birth Sex: □ Male □ Female	**Sexual Orientation**: □ Straight □ Lesbian or Gay □ Bisexual □ Other □ Choose Not to Disclose
Gender Identity: □ Male □ Female □ Transgender - Male to Female □ Transgender - Female to Male □ Other	
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

❒ Medicaid ❒ Medicare ❒ VA Healthcare ❒ Other ❒ No Insurance	
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/client provide food and shelter for him/herself?*	

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HOMELESS VERIFICATION DOCUMENTATION

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

❒ Living on the streets or in a place not meant for human habitation

❒ Recently incarcerated

❒ Emergency Shelter

❒ Living with friends/family

❒ Lost home/housing

❒ Other _____

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

_____ _____

Referring Source Name *Date*

_____ _____

Referring Source Signature *Hospital Name/Organization*

PRIMARY CARE PROVIDER INFORMATION

Does this patient/client 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.

_____ _____ _____

Patient/*Client Signature* *Date* *Hospital/ Organization*

_____ _____

Referring Source Name *Date*

MENTAL HEALTH RISK ASSESSMENT

Patient/Client Name: _____ **Date**: _____

Does patient/client have any of the following? *Check all that apply*

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

❒ Psychosis w/ uncontrolled symptoms ❒ Mood instability

❒ Confusional state/ dementia ❒ Major Interpersonal Conflict

❒Substance withdrawal symptoms ❒ Recent Loss

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

During the hospital stay has client been on restraints? ❒Yes ❒No

Goal oriented ❒Yes ❒No **Availability of firearms** ❒Yes ❒No **Impulsive self-injury** ❒Yes ❒No

Previous suicide attempt ❒Yes ❒No **Last attempt** (date): _____

If yes, method of attempt(s): _____

Current plan for self/other harm ❒Yes ❒No

Substance abuse/dependence ❒Yes ❒No **Last use** (date): _____ **Completed detox?** ❒Yes ❒No

Recent use of ETOH ❒Yes ❒No **Last use** (date): _____ **Completed detox?** ❒Yes ❒No

Additional Comments: _____

_____

_____

Referring staff signature: _____

COMMUNITY MEDICAL RESPITE
PROGRAM INFORMATION & EXPECTATIONS

Daily Planet Health Services (DPHS) Medical Respite is a short-term specialized 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) patients/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 during your stay who will assist you in developing a plan for your recovery and housing.

The staff is available to help you during your recovery. 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, we ask that you sign in and out when leaving and returning. For safety reasons, all patents/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. Patients/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 Patient/Client Handbook, including rights and responsibilities, and will be provided upon admission. Please sign below to indicate that you have reviewed these expectations.

_____	_____	_____
Patient/Client Signature	*Patient/Client Printed Name*	*Date*