MEDICAL RESPITE REFERRAL REQUEST FORM

Fax: 804-451-5990 **Phone**: 804-292-3030 **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.

Client Name: ____________________________ **DOB:** ______________________ **SSN:**________________________

EXCLUSION CRITERIA – if the answer to any of these is Yes, we cannot admit patient

Yes / No

❒ ❒ Registered Sex Offender
❒ ❒ Recent history of violent behavior (will not admit)
❒ ❒ Displays suicidal or homicidal ideations; or shows gross disorientation or hallucinations
❒ ❒ Currently Employed

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ADMISSION CRITERIA - all answers must be Yes to be admitted

Yes / No

❒ ❒ Over age 18 and homeless
❒ ❒ Medically stable as verified by physician documentation
❒ ❒ COVID vaccination complete or in progress, or willing to receive vaccine upon arrival to respite
❒ ❒ Psychiatrically stable as verified by physician/ psychiatrist statement as applicable
❒ ❒ 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
❒ ❒ Able to exit the building with minimal assistance in the event of emergency
❒ ❒ Willing to meet with Medical Respite staff and other health care providers when needed
❒ ❒ Able to function in a group setting

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ADDITIONAL INFORMATION

Primary DX (*ACUTE*) ________________________________Secondary DX ______________________________________

Hospital Admit Date: _________________Discharge: __________________ Expected Admit Date to Respite:________________

Distance able to walk? __________ Assistive Devices?:_______________ Able to climb stairs? ❒ Yes ❒ No

Continent?_______________ Wound Care Needs? ________________ PT/OT Home Health Needs?__________________________

Home Care agency _________________________________Phone Number_________________________# of Visits: _____________

ADMISSION DOCUMENT CHECKLIST – PATIENT MUST HAVE PRIOR TO ADMISSION

❒ Minimum 30-day supply of prescribed medication(s), and a 30-day supply of wound care supplies if indicated
❒ List of current prescribed medications and post hospitalization follow up appointments/ Discharge Summary
❒ Proof of TB test or copy of chest X-ray completed within the last 12 months
❒ Proof of COVID Vaccination
❒ Completed DPHS Registration Packet – can be found on DPHS website

REFERRAL SOURCE CONTACT INFORMATION

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

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

Effective 10/2021

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MENTAL HEALTH RISK ASSESSMENT

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

❒ 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

During the hospital stay, has patient required PRN sedatives? ❒Yes ❒No

History of self-injury ❒Yes ❒No **Previous suicide attempt** ❒Yes ❒No

Last attempt (date): ____

If yes, method of attempt(s): ____

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: ____

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PRIMARY CARE PROVIDER INFORMATION

All clients will have a medical team directing their care while staying at Medical Respite. If the patient has a PCP, we will communicate their progress to the PCP; otherwise, DPHS will become the client's PCP.

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

If yes, PCP Name____ Phone #:_______________________________

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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 Signature *Date*

Referral Source Name: ____

Phone # ___________________________

Email (required) _______________________________________

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COMMUNITY MEDICAL RESPITE

PROGRAM INFORMATION & EXPECTATIONS

Daily Planet Health Services (DPHS) Medical Respite is a short-term recuperative care program for adults with medical or behavioral health 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) above our primary care and dental practices. During your stay, you will be seen by a medical provider and a case manager. You will have the option of participating in behavioral health group, recovery group, and health education classes. Psychiatry, individual behavioral health therapy, and Peer Recovery Support services are also available by request. You are encouraged to accept DPHS as your medical home after discharge.

The DPHS medical provider and case manager will work with you to develop a plan of care during your stay. This plan will include resolving barriers to housing placement. You will be provided three meals daily. We do everything we can to make your stay at Daily Planet Medical Respite pleasant and productive.

SIGNING IN/OUT

If you are partially vaccinated against COVID, you must remain on medical respite grounds to avoid catching COVID in the community and bringing it back to our facility. Once you are fully vaccinated against COVID, most clients are able to come and go during the daytime hours so long as their provider feels it's safe for them to leave, and they sign in and out each time. All clients are to be in the facility by 5:30 PM.

MEDICATIONS

For everyone's safety, all medications are kept in a secure location during your stay. In order to assist in your recuperation, medical providers will write care orders and staff will assist you when taking medications.

SMOKING

Medical Respite is a **Smoke Free** program. Smoking is not allowed inside the facility. There is a designated smoking area outside, and help with smoking cessation will be offered during your stay.

SUBSTANCE USE

Medical Respite is a **Drug and Alcohol-Free** program. 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.

PATIENT BELONGINGS

Medical Respite is a **Weapons Free** program. No firearms are allowed on site. All your belongings will be checked and disinfected upon arrival. Any potentially harmful belongings will be checked in upon admission and returned to you upon discharge. No open flames of any kind are allowed inside the building, (i.e. candles, incense, etc.). If you have an automobile, you must show your license and insurance to park in the Medical Respite parking lot. Keys are left with staff for security and checked out when needed.

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.

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