HEALTH CARE FOR THE HOMELESS, INC.

CONVALESCENT CARE ADMISSION/REFERRAL

Date of Referral:

Primary Diagnosis: Category:

Details:

Referring Agency:

Agency Contact:

Reason for Referral:

Accepted? ☐ Yes ☐ No Reason:

Comments:

Primary Care Provider:

Provider Phone #:

CURRENT CLIENT BENEFITS

☐ Pharmacy Assistance ☐ PCMI ☐ Medical Assistance ☐ Unknown

☐ Medicare ☐ VA ☐ None ☐ Comments:

SECONDARY DIAGNOSIS

CATEGORY						
General	☐ AIDS	☐ HIV	☐ Anemia	☐ Cancer	☐ **Surgery**	☐ Tobacco Use
Cardiovascular	☐ CAD	☐ HTN	☐ CHF	☐ DVT	☐ **Other**	☐
Endocrine	☐ DM/1	☐ DM/2	☐ Thyroid	☐ Gout	☐ Other	☐
Neurologic	☐ **Seizures**	☐ **Stroke**	☐ **Headache**	☐ **Other**	☐	☐
Gastrointestinal	☐ Gastritis	☐ GERD	☐ **Hepatitis B**	☐ **Hepatitis C**	☐ **Pancreatitis**	☐ Peptic Ulcer
Musculoskeletal	☐ Arthritis	☐ Back Pain	☐ Sprain/Strain	☐ DJD	☐ Fracture	☐ Other
Psychiatric	☐ **Depression**	☐ Bipolar	☐ **Schizophrenia**	☐ **Other**	☐	☐
Respiratory	☐ **Asthma**	☐ **Bronchitis**	☐ **Emphysema**	☐ **Pneumonia**	☐ **URI**	☐ **Other**
Genitourinary	☐ **Renal Failure**	☐ **Prostate**	☐ **Kidney Infection**	☐ **Dialysis**	☐ **Other**	☐
Dermatologic	☐ **Skin Disorder**	☐ **Wounds**	☐ **Burns**	☐ Cellulitis	☐ **Other**	☐
EENT	☐ **Thrush**	☐ **Dental**	☐ **Eye Problem**	☐ **Other**	☐	☐
Miscellaneous	☐	☐	☐	☐	☐	☐

☐ IVDU ☐ NIVDU ☐ ETOH Last Use: Comments:

☐ Allergies:

Women: LMP________________ ☐ Regular ☐ irregular **Para:**

☐ Meds:

Comments:

Treatment Plan:

Emergency Contact:

Date of Birth: SS#: Sex: Race:

CLIENT LAST NAME: **FIRST:** **HCH#:**

Physical Examination

ROS

NEURO:

CV:

Resp.:

GI:

GU:

EENT:

Skin:

Indicate Location and Shape of Skin Abnormalities of Figure Below:

Front *Back*

Notes: