180 Belt Blvd, Richmond, VA 23224 ***Effective 2/2017***

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. The Program operates 24 hours/7 days a week; however, patients are admitted between 8:00 AM and 3:30 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 Five (6) pages of Referral should be included with other documents when faxed. **Please allow 24 hours for Referral to be reviewed.**

Appropriate referrals are those whose condition is reasonably expected to improve within 30 days.

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

Reason why client is inappropriate for SHELTER SYSTEM:____

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

Allergies: ____ Special Diet Needs: ____

Injury- related weight bearing: ❒ Full, all extremities ❒ Other_____________ Can Walk Pt. walk at least 250ft? ________Climb 18 stairs: __________

Wound Care orders with____# of Visits: ____________________________

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

ADMISSION CRITERIA

Note: This Facility is NOT equipped to admit clients with IV lines, oxygen (tanks) or Chest tubes.

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
❒ ❒ Independent ability to exit the building in case of an 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 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-DP Letterhead) (Page 4)
❒ ❒ List of current prescribed medications
❒ ❒ Copy of Physician Discharge Summary
❒ ❒ 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**_______________________________________

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 Email:____**Telephone:**_____________________________

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
❒ Not Hispanic

Does This Patient PCP?_________

If yes PCP Name____PH_______________________________

If NO patient will need to sign agreement that Daily Planet will become their PCP if approved for Program

Insurance Status: VCC ❒Yes ❒No
VCC Pending ❒Yes ❒ No
Medicaid ❒ Yes ❒ No
Medicare ❒ Yes ❒ No

Recently lost health benefits ❒Yes ❒No
Recently lost a Job ❒Yes ❒No
Any Financial & Non-Financial benefits ❒Yes ❒No
(ssi, ssdi, retirement, disability)

If YES Amount_________________
Food Stamp__________

❒ **Participate is totally Indigent**

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

Homeless Verification Documentation Form

I verify that this patient, ____, is homeless (living on the street or in a place not meant for human habitation, or emergency shelter), and that he/ or she is in need of respite care. I am referring this patient to The Daily Planet's Community Medical Respite for short term convalescent services at this time.

______________________________________ ________/________/__________

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 the Daily Planet will become my PCP once I enter the program.

___________________________________ ________________________

Client Signature **Date**

____

Hospital/ Organization

_________________________________ ________________________

Referring Source Name **Date**