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**RECUPERATIVE CARE PROGRAM**  
 Case Manager Referral Form  
 (TO BE COMPLETED BY SOCIAL SERVICES)

Date and Time of Referral: \_\_\_\_\_  
 mm/dd/yr \_\_\_\_\_ Time

JWCH Recup Care Contact Person:  Marisa Samano  Melinda Garbutt  Other: \_\_\_\_\_

Ref. Agency: \_\_\_\_\_ Person making referral: \_\_\_\_\_ Contact#: \_\_\_\_\_  
Please Print

Patient Name: \_\_\_\_\_ Re-admission Request:  Yes  No

DOB: \_\_\_\_\_ SS#: \_\_\_\_\_ Gender:  M  F  Other \_\_\_\_\_

Is patient homeless?  Yes  No If yes, please attach verification letter.

Usually resides at/near: \_\_\_\_\_ Usual source of medical care: \_\_\_\_\_

Substance abuse:	Past Use		Current Use		Last Used	Is the patient:		
	Y	N	Y	N		Y	N	
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Sex offender?	<input type="checkbox"/>	<input type="checkbox"/>
Heroin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Convicted of a sexual crime	<input type="checkbox"/>	<input type="checkbox"/>
Cocaine/crack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Arsonist	<input type="checkbox"/>	<input type="checkbox"/>
Opiates	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	History of assault on an officer	<input type="checkbox"/>	<input type="checkbox"/>
Benzo	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Unstable med or psychiatric conditions?	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Require higher level of care <small>(i.e. Convalescent, skilled nursing)</small>	<input type="checkbox"/>	<input type="checkbox"/>

**S3: C-11**      **IMPORTANT, Pls Complete**  
 (Follow-up Appts After Discharge)

Specialty	Date	Time	RM #	Contact #

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 Click here to view FULL follow-up appt record

Form Completed By: \_\_\_\_\_  
 Signature