Referral forms

Patient Name _____ DOB_____

Yakima Neighborhood Health Services
12 South 8th St, PO Box 2605
Yakima WA 98907-2605
www.ynhs.org

Hospital or Medical Provider – Referral of Homeless Person for Respite Housing:

1. Contact YNHS Outreach at (509)249-6232 (Monday – Friday) to identify if housing shelter is available (before completing this form).
2. Fax this Referral Form + Hospital Discharge patient instructions including H/P to Yakima Neighborhood Health 107 house at (509)249-2800.

Referring Medical Provider

Provider Name:	**Soc.Serv Pager/Phone:**
Hospital or Clinic:	**Service:**

Is YNHS the PCP ? ___Yes If not, who is / will be _____

Referring Medical Provider to Complete all Following Sections

Respite Criteria – Check Boxes Below (must meet all criteria)

Homeless or in Emergency / Transitional Housing		Willing to see respite staff daily and can comply independently with medical recommendations from medical provider	
Acute medical problem that would benefit from short-term respite		Behaviorally appropriate to be left alone (including no known suicidal or assaultive risks)	
Independent in ADL's including medication administration		No intravascular lines	
Independent in mobility		Does not require > 4 week respite stay	
Continent of urine and feces		Does not need SNF placement	
Medically stable		Patient understands respite facility is alcohol and drug free	
Has not received benzodiazepines for alcohol withdrawal in past 24 hours			

Diagnosis requiring respite:_____ _____Anticipated Stay Needed _____ Days

 # Days patient was hospitalized _____ W/O Respite, Days longer you would keep Patient _____

Last Vital Signs: T max_____ BP_____ HR_____ RR_____ RA O2 Sat___

ETOH:	**Yes**	**No**	**Extremity**	**Wt. Bearing**	
Hx ETOH SZ:	**Yes**	**No**	**RLE**	**FULL**	
Hx DT's:	**Yes**	**No**	**LLE**	**WBAT**	**Allergies_____**
Drugs	**Yes**	**No**	**RUE**	**TTWB**	**Diet _____**
			LUE	**NWB**	**Psych Dx_____**
					Psych F/U_____

Special monitoring, activity restrictions (if not on Discharge Instruction Forms):

_____

- Attach Current or Discharge Medication List , H& P, and Hospital Facesheet.

Medical Provider Signature:_____ Date:_____