ILLUMINATION FOUNDATION
RECUPERATIVE CARE

Inland Empire REFERRAL FORM

To refer a patient, please complete the entire form including supporting documents and **FAX** to **(951)801-5112** or **email** to RECUP@ifhomeless.org For all referral questions, please contact IF Referral Coordinator at **(951) 708-6000**

Referring Hospital:______________________________ **Dept/Floor:**______________________________
SW/CM/RN:______________________________ **Phone/pager#:**______________________________
E-mail:______________________________ **Nursing station#:**______________________________
Authorized by:______________________________ **phone#:**______________________________

Patient Name: ______________________________ **MRN**______________ **Date of Birth**:_____ /_____ /______

Gender: ☐ Male ☐ Female ☐ Transgender **Ethnicity:** ____________ **Social Security# (last 4):** xxx-xx-__________

☐**ED Visit** ☐**Hospital Admit** **Date**_____ /_____ /________ **Expected Discharge Date:** ____ /_____ /________

Insurance Type: ____________________ **English Speaking?** ☐ Yes ☐ No ***Primary Language Spoken:** ______________

PLEASE VERIFY: ☐**Currently homeless** **Check if:**☐ **Homeless for more than 1 year continuously or 4 episodes in last 3 years**

CHIEF COMPLAINT/ADMITTING DIAGNOSIS:

____

SUBSTANCE ABUSE? ☐ None ☐ Alcohol ☐ Cocaine ☐ Heroin ☐ Meth ☐ Other: ____________________
Last Date Used: ____ /____ /________ Current withdrawals: ☐ No ☐ Yes *Please explain______________

ANY WOUNDS? ☐ Yes ☐ No #/Loc/Size/Stage:____

Independent with wound care?☐ Yes ☐ No If no, will Home Health be ordered? ☐ Yes ☐ no

PPD/TB test or Chest XRAY performed? ☐ yes ☐ no Date:______________ Results:_______________

ANY LIMITATIONS, BEHAVIORAL CHALLENGES OR MENTAL HEALTH ISSUES? ☐ None ☐ Auditory/Visual Hallucinations

☐ Mental Health DX IF yes, **what type**?:______________________________ ☐ Non-compliant ☐ forgetful

☐ Cognitive Impairment ☐ Reg. Sex offender ☐ other, please explain ______________________________

____

Requires O2? ☐ Yes ☐ No Self Administer All Meds? ☐ Yes ☐ No *Please explain:_________________________
Continent of Bowel & Bladder? ☐ Yes ☐ No Colostomy/Ileostomy ☐ Yes ☐ No Foley Catheter ☐ Yes ☐ No
Independent w/all ADL's? ☐ Yes ☐ No *Please explain:______________________________
Diabetic? ☐ No if ☐ Yes, then: ☐ Insulin ☐ Oral Meds Communicable Diseases?:____________________
Anticoagulants?: ☐ No IF ☐ yes, Requires INR/PT/PTT checks through Home Health or Clinic? ____________
Ambulatory? ☐ Yes ☐ No Assistive device? ☐ No ☐ Yes *Please Explain:______________________________
Does Patient have a car? ☐ Yes ☐ No Spouse/Partner? ☐ Yes ☐ No Service Animal? ☐ Yes ☐ No

Length of Stay authorized in Recuperative Care:____days

Attached Docs: ☐ **Face Sheet** ☐ **H&P** ☐ **Med List** ☐ **Psych notes** ☐ **Surgical notes** ☐ **PT/OT Eval.** ☐ **SW notes**

IF STAFF ONLY

Date Received:__________ Reviewed by:____________________ Approved: ☐ Yes ☐ No Date:________ Auth#_______
Denied Reason?:______________________________ Admission Date/time:______________ Exit Date:_____________
Extension Requested?:☐ no ☐ yes If yes, Approved additional days?:_______ by:______________ TOTAL LOS:___________

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