

To refer a patient, please complete the entire form including supporting documents and **FAX to (888)382-9551** or **email to RECUP@ifhomeless.org** For all referral questions, please contact IF Referral Coordinator at **(888)505-0855**

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