



In-Patient Facility Discharge Referral

Instructions: Complete Sections 1-4 as needed. If patient was admitted for **physical health concerns only**, complete sections 1, 2, and 4. If Patient was admitted for **behavioral health concerns only**, complete sections 1, 3, and 4. If patient was admitted for **both** behavioral concerns and physical health concerns complete sections 1-4. Please fax completed referral to Haven for Hope Intake Department.

□ Section 1:

Patient Name: _____ DOB: _____

MRN: _____ Name of Hospital/Facility: _____

● **Admitting Diagnosis:**

● **Discharge Diagnosis:**

□ Section 2: (Physical Health)

● **Is the patient able to meet the following ADLs independently?**

By initialing below, the physician confirms that the patient is able to complete the following without any assistance:

Initials:

_____ Bathe

_____ Toilet

_____ Dress

_____ Self-Feed

_____ Self-Medicate

_____ Able to perform wound care

_____ Ambulate greater than 300 feet without assistance (indicate in comments if patient requires mobility device)

_____ Transfer to and off the floor

Need for DME: _____

Oxygen: _____

Wound Vac: _____

Comments:

□ Section 3: (Behavioral Health)

● **Attending Physician:**

By initialing below, the physician confirms the following:

Initials:

_____ Symptoms and concerns have been addressed while in care

_____ Patient is independent on Activities of Daily Living (ADLs) – Able to ambulate 300 feet



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□ Section 4:

- Follow-Up appointments, Scheduled Visits with Specialist(s):

Physician/Clinic Name:	Address:	Date / Time of Appt.:

- List of Medications at Discharge:

- File must include the following medical records:

- € Client Face/Demographic Sheet
- € H&P (History and Physical)
- € Last Physician’s Progress Note
- € Physical Therapy (PT) / Occupational Therapy (OT) Notes *(If Ordered)*
- € Psychiatric Follow Up Appointment *(Behavioral Health Patients Only)*
- € Behavioral Health Assessment / Psychiatric Evaluation *(Behavioral Health Patients Only)*
- € Discharge Summary *(If Available)*

Comments:

Attending Physician:

Printed Name: _____ Phone: _____
 Signature: _____ Date: _____

Care Coordinator / Case Manager / Social Worker:

Printed Name: _____ Phone: _____
 Signature: _____ Date: _____

- Fax email completed referral to intakeinfo@havenforhope.org or fax to 210-910-6868.
- Monday – Friday 8:00 am – 3:00 pm



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