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: _____

Email Address: _____

Signature: _____ Date: _____

- **Fax email completed referral to intakeinfo@havenforhope.org or fax to 210-910-6868.**
- **Monday – Friday 8:00 am – 3:00 pm**
- **Please allow 24 hours turn around for an Intake decision.**