



In-Patient Facility Discharge Referral

Instructions:

- **Complete Sections 1-4 as follows:**
 - 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 and physical health concerns complete sections 1-4.
- **Email completed referral to intakeinfo@havenforhope.org or fax to 726-226-0713.**
 - **Monday – Friday, 8:00 am – 5:00 pm**
 - **Please allow 24 hours turn around for an Intake decision.**

Section 1:

Patient Name: _____ DOB: _____

MRN: _____ Name of Hospital/Facility: _____

Will patient be referred to Haven for Hope’s Veteran Services if approved for Intake? Yes No

- **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 | Need for DME: _____ |
| _____ Toilet | Oxygen: _____ |
| _____ Dress | Wound Vac: _____ |
| _____ Self-Feed | |
| _____ Self-Medicare | |
| _____ 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 | |

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: _____