Recuperative Care Referral Form

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More information and admission criteria are available at **roomintheinn.org/recuperativecare**.

Attached H&P, Admission Note, and Discharge Medicine List? Yes ☐ No ☐

Will you be filling prescriptions for this person? Yes ☐ No ☐

Will the patient be coming with any narcotics? Yes ☐ No ☐

Please note that we partner with the Dispensary of Hope to fill prescriptions. There is a 24-hour turn around.

Patients Name: _____ Date of Birth: _____

SSN: _____ Sex: _____ Veteran: Yes ☐ No ☐

Race (please select all that apply): ☐ American Indian/Alaska Native ☐ Asian

☐ Black/African American ☐ Native Hawaiian/Pacific Islander ☐ White

Hispanic/Latino: Yes ☐ No ☐

Where was the patient living before admittance? _____

Does patient have any income? If so, what is the source & amount? _____

Does patient have insurance? If so, name of insurance group. _____

What is the patient's plan for what they will do once their recuperative care stay is up?

_____

Acute medical problem: _____

Secondary diagnosis: _____

Notes: _____

_____

_____

Does the patient require assistance with any ADLs (toileting, dressing, transfers, etc.)? Yes ☐ No ☐

Is the patient ambulatory? Yes ☐ No ☐ Assistive device needed? _____

Psychiatric diagnosis:_____ Treatment: _____

Does the patient have alcohol or drug addiction? Yes ☐ No ☐

Follow up appointment day, time and place: _____
Please be specific. Give address and phone number.

Referred by:_____ Phone:_____Pager: _____

Department: _____ Email: _____

Was this person in the hospital for medical or surgery-related services? Medical ☐ Surgery ☐

MEDICAL PATIENTS

Does the patient have any contagious illness?
Yes ☐ No ☐ If yes, describe: _____

Does the patient have any type of lice or scabies?
Yes ☐ No ☐

If there was an infection, has it cleared?
Yes ☐ No ☐

Did this person have diarrhea in the hospital?
Yes ☐ No ☐

If so, is it controlled now? Yes ☐ No ☐

Medical supplies needed for patient care:
_____

Hospital supplied? Yes ☐ No ☐

What is the pain management plan for this patient?

_____

SURGICAL PATIENTS

If there was an infection, has it cleared?
Yes ☐ No ☐

Did this person have a heart related procedure?
Yes ☐ No ☐

Will this person need home health care? Yes ☐ No ☐
If so, agent:_____
Phone:_____

Will this person need physical therapy? Yes ☐ No ☐
If these services are needed, they must be arranged prior to discharge to recuperative care.

Medical supplies needed for patient care:
_____

Hospital supplied? Yes ☐ No ☐

What is the pain management plan for this patient?

_____

Will this patient have a catheter? Yes ☐ No ☐

Will the patient have a colostomy bag? Yes ☐ No ☐

Is the patient dealing with cancer? Yes ☐ No ☐

If so, in what stage are they? _____ Is the patient aware? Yes ☐ No ☐

Notification of Privacy Rights

We collect personal information about you to improve our services for you. We are required by law and organizations that fund us to collect and share certain personal information. Some of the information you provide will be entered into a Nashville area database in an effort to coordinate and improve local services in the future. This information includes name, gender, date of birth, social security number, veteran status, ethnicity, race, and whether you have a disabling condition (the condition will not be listed). Individually identifiable health information will not be entered into the database. As required by law, the database will be protected by many layers of security and will only be accessible to authorized Nashville database users and as otherwise required by applicable law. Your eligibility to receive services from Room In The Inn will not be conditioned on whether you sign this consent. You can revoke your consent at any time. However, your revocation will not be effective to the extent that we have already acted in reliance on your consent. For more information regarding the privacy of your personal information, please see the "Room In The Inn Notice of Privacy Practices," available at the Room In The Inn front desk.

The information that I have given on this form is correct to the best of my knowledge. I have read the above "Notification of Privacy Rights," and a copy of the "Room In The Inn Notice of Privacy Practices" has been made available to me. I expressly authorize and consent to my personal information being entered into the Nashville area database.

I give permission for the information on this recuperative care referral form to be shared with Room In The Inn.

_____
Patient Signature

_____ _____
Date Hospital