SCHC HOPE Medical Respite Referral Worksheet

The intent of our program is to provide care for homeless individuals who are recovering from an acute or post-acute medical condition. The Medical Respite program is designed to provide a safe place to recover for people experiencing homelessness who are discharged from the hospital, or those failing to thrive in the shelter system or on the streets due to acuity of medical conditions. This program is a partnership between Shasta Community Health Center and Pathways to Housing. Program length cannot exceed 8 weeks.

Please complete this form to the best of your ability. Once this form is received by our RN, the patient will be interviewed by the medical representative of our Medical Respite Care Team to determine appropriateness for admission and patient's ability and willingness to engage in their medical care. This is a harm reduction, housing first focused program that aims to balance patient safety and their ongoing medical needs. Completed forms can be sent to our Medical Respite e-fax +1 (866) 394-7926.

Patient's Name:_____ DOB:_____

Patient's Preferred Pronouns:_____ Patient's Identified Gender:_____

MRN: _____ Current Pt Location:_____ Rm #:_____

Hospital MD/Provider:_____ Provider's Contact #/Pager:_____

Hospital staff contact name (Case Management):_____

Phone #:_____

Homeless Status Verified: Y N Living Situation prior to hospitalization:

_____

MEDICAL REASON FOR REFERRAL (ACUTE):_____

_____

_____

_____

Anticipated recovery length of service should be 4-6 weeks):_____

_____

Does patient require wound care (if so, please describe the wound, location and size and current treatment plan):_____

_____

Anticipated D/C Date from hospital:_____ Recent hospitalization/currently hospitalized? Y N

Admit Date:_____ Any surgeries?_____

Specialty follow-up required: Y N Scheduled Appts (with dates):_____

_____

Insured: Y N Current Insurance Coverage:_____

Any communicable diseases?	Y N	Patient requires oxygen?	Y N
Able to care for self:	Y N	Bowel & bladder continent?	Y N
Ambulatory?	Y N	Assistive device used?	Y N
Indwelling catheter?	Y N	Can patient self-administer meds?	Y N
Requires insulin?	Y N	Does patient have PICC line?	Y N

Patient agreeable to admission to recuperative care: Y N

Details from answers above:_____

_____

What is the plan for patient's prescriptions at the time of discharge?_____

_____

Is patient also eligible for SNF: Y N Has patient been denied by SNF because of disposition issues? Y N

Does the patient have any Mental Health symptoms, diagnoses or behaviors?

Details:_____

_____

_____

_____

_____

What is the patient's substance use history?

Details:_____

_____

_____

_____

_____

Has the patient been arrested or convicted of a sexual offense, violent offense, arson or a drug-related manufacturing charge that could be a barrier to accessing community resources or housing?

Details:_____

_____

_____

_____

_____

_____

TO BE COMPLETED BY MEDICAL RESPITE STAFF AT THE HOSPITAL OR IN THE FIELD :

1) Does the patient have any belongings that they will be bringing with them if admitted, if so, how many?

2) Does the patient have any animals that they will be bringing with them, if so, has a plan of care been discussed with them, including hotel?

3) Does the patient have children that they will be having stay with them? If so, please refer to the assessment protocol for children in the program.

4) If the patient has safety concerns, please alert SCHC Leadership so they can coordinate a safety staffing with Pathways as a component of the assessment.

5) If the patient is from outside of the County, the SCHC team needs to review with patient their discharge plan, prescription coverage and goal of time in program prior to admittance so we can proactively plan around barriers to care for out-of-county patients.