

# Recuperative Care Center Preliminary Referral Form

To refer a patient from your hospital, please complete entire form and fax to 877-551-5580

Call National Health Foundation at 714-703-1875 or 213-538-0769 with referral questions.



Referring Hospital: \_\_\_\_\_ Attending Physician: \_\_\_\_\_  
Discharge Planner: \_\_\_\_\_ Phone #: \_\_\_\_\_ Pgr: \_\_\_\_\_  
Case Manager: \_\_\_\_\_ Phone #: \_\_\_\_\_ Pgr: \_\_\_\_\_  
Authorized by: \_\_\_\_\_ (For internal Hospital Use)

## Patient Information

Name: \_\_\_\_\_ MRN: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Date Admitted to Hospital: \_\_\_\_/\_\_\_\_/\_\_\_\_

Anticipated discharge date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Please explain the medical reason for hospital admission:

\_\_\_\_\_  
\_\_\_\_\_

Please explain any surgical procedures and/or patient limitations:

\_\_\_\_\_  
\_\_\_\_\_

Is wound care required?  Yes  No If Yes: Size \_\_\_\_cm by \_\_\_\_cm Depth \_\_\_\_cm Stage \_\_\_\_

Is Home Health needed?  Yes  No If Yes, please explain: \_\_\_\_\_

Does the patient have any mental or substance abuse issues?

Mental Health:  Bipolar  Depression  Schizophrenia  Other: \_\_\_\_\_

Substance Abuse:  Alcohol  Cocaine  Heroin  Methamphetamine  Other: \_\_\_\_\_

Any other medical or behavioral problems? \_\_\_\_\_

\_\_\_\_\_

Requires Oxygen?  Y  N Self-administer medicine?  Y  N If No:  Needs reminders  Needs assistance

Continent of Bowel & Bladder?  Y  N Requires IV Antibiotic?  Y  N Communicable disease?  Y  N

Ambulatory?  Y  N Assistive device?  Y  N If Yes:  Walker  Cane  Wheelchair  Crutches  Other: \_\_\_\_\_

Blood work (Coumadin)?  Y  N Diabetic?  Y  N If Yes:  Requires Insulin?  Y  N

Estimated length of stay in recuperative care center: \_\_\_\_\_ days

\_\_\_\_ Medications List (please fax)

### FOR RECUP STAFF USE ONLY

Approved?  Y  N If denied, reason: \_\_\_\_\_

Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

Admission Date: \_\_\_\_\_ Time: \_\_\_\_\_ Hospital Update:  Y  N

Discharge Date: \_\_\_\_\_ Time: \_\_\_\_\_ Patient Summary:  Y  N

Referral ID:  LA  OC

Language: \_\_\_\_\_

1<sup>st</sup> F  2<sup>nd</sup> F

MediCal  OTHER: \_\_\_\_\_

NOTES: