

Los Angeles Recuperative Care Program: Preliminary Referral Form



To refer a patient from your hospital, please fax or email completed form.

Call Elizabeth Yang, Director of Recuperative Care Program at 213-538-0769 with any questions

Referring Hospital: _____ Attending Physician: _____
Discharge Planner: _____ Phone #: _____
Case Manager: _____ Phone #: _____ Pgr: _____

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 program: _____ days _____ Medications List (please attach)

FOR NHF STAFF USE ONLY

Approved? Y N If denied, reason: _____

Reviewed by: _____ Date: _____ Time: _____

Admission Date: _____ Time: _____ Hospital Update: Y N

Discharge Date: _____ Time: _____

Notes:

Referral ID: _____

1st Floor 2nd Floor

Insurance: _____