Respite Care Referral Form

532 8th Ave South Nashville, TN 37203
P: 615-251-7064 F: 615-251-3274

Attached H&P: Yes ☐ No ☐

Attached Discharge Medicine List: Yes ☐ No ☐

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

Patients Name:______________________________ DOB:____________________

SSN:__________________ Male: ☐ Female: ☐ Veteran: Yes ☐ No ☐

Where was the patient living before admittance?___________________________

Does patient have any income?____

Does this patient have a plan for what they will do once their respite stay is up?

____

Has this patient been cleared by your MD's to come to respite? ________________

Acute medical problem:____

Secondary diagnosis: ____

Recommended length of stay: ☐ 3 days ☐ 10 days ☐ 14 days ☐ 30 days

Note: No respite participant will be allowed to stay past thirty days without a new referral.

Notes:____

____

Is the patient ambulatory?____

Date of last TB test:________ Results:________ Treatment given:______________

Psychiatric diagnosis:___________________ Treatment:_______________________

Does the patient have alcohol or drug addiction?____________________________

Follow up appointment day, time and place:_________________________________

Referred by:________________________ Phone:_____________ Pager:____________

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

Medical	Surgery
Has this person been cleared by your MD's to come to respite? If there was an infection, has it cleared?__________ Does the patient have scabies?_______ Does the patient have any GI issues that require a special diet?_______________ If so, what diet?____________________ Did this person have diarrhea in the hospital?__________ If so, is it controlled now?___________ Medical supplies needed for patient care:______________________________ Hospital supplied? Y☐ N☐ What is the pain management plan for this patient?_______________________ _________________________________ _________________________________	Has this person been cleared by your MD's to come to respite? If there was an infection, has it cleared?__________ Did this person have a heart related procedure?________________________ Will this person need Home Health?___ If so, agent:________________________ Phone:____________________________ Will this person need physical therapy?_______ If so, can you set this up?____________ Medical supplies needed for patient care:___________________________ Hospital supplied? Y☐ N☐ What is the pain management plan for this patient?_______________________ _________________________________ _________________________________

Is the patient dealing with cancer? Yes ☐ No ☐

If so, what stage are they in? __________

Patient's signature consent for transfer of information:________________________

Date:________________ Hospital:____________________________

Staff Only

Date:_______________

Accepted ☐3 days ☐10 days ☐14 days ☐30 days Declined________

Arrived? ☐Yes ☐No
Arrival Date:_____________

Entered into GHR:☐
Log report placed in shift log:☐