



Respite Care Referral Form

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www.roomintheinn.org

Attached H&P: Yes No

Attached Discharge Medicine List: Yes No

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

Will the patient be coming with any narcotics? Yes No

Patients Name: _____ DOB: _____

SSN: _____ Male: Female: Veteran: Yes No

Where was the patient living before admittance? _____

Does patient have any income? _____

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

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 7 days 14 days

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

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? _____

Surgery

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? _____

Will the 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, what stage are they in? _____

Patient's signature consent for transfer of information: _____

Date: _____ Hospital: _____

Staff Only

Date: _____

Accepted 3 days 7 days 14 days Status: _____

Arrived? Yes No
Arrival Date: _____

Entered into GHR:
Log report placed in shift log: