REFERRAL FORM

1. COMPLETE ENTIRE FORM – GATHER DOCUMENTS – **FAX: (323) 998-7614**
2. DOCUMENTS (**Face Sheet, H/P, Med List, Psych notes, PT/OT Eval, SW notes, MD Progress Notes)**
3. OR EMAIL TO LKNOX@FTKNOX4VETS.ONMICROSOFT.COM
4. FOR ALL REFERRAL QUESTIONS, PLEASE CONTACT COORDINATOR **(323) 386-1387**

Client Name: _____ MRN: _____

Date of Birth: _____ Gender: ❑ Male ❑ Female ❑ Transgender

Ethnicity: ❑ Asian ❑ Black ❑ Hispanic ❑ White ❑ Other: _____

Social Security Number (last 4 only): xxx-xx-_____ ED Visit / Hospital Admit Date: _____

Hospital: _____ Dept. / Floor: _____

SW/CM/RN: _____ Phone/pager Number: _____

E-mail:_____ Nursing station Phone No.:_____

Authorized by: _____ Phone Number: _____

Expected Discharge Date: _____ Insurance Type: _____

English Speaking: ❑ Yes ❑ No Primary Language: _____

Currently homeless: ❑ No ❑ Yes - Homeless for more than 1 year or 4 episodes in last 3 years: ❑ Yes ❑ No

CHIEF COMPLAINT/ADMITTING DIAGNOSIS: _____

SUBSTANCE ABUSE: ❑ No ❑ Yes Alcohol/ Cocaine/ Heroin/ Meth Other: _____

Last Date Used: _____ Current substance abuse withdrawal: ❑ No ❑ Yes Please explain: _____

_____

ANY WOUNDS: ❑ No ❑ Yes How many / Location / Size / Stage: _____

_____

Independent with wound care: ❑ Yes ❑ No **If no**, will Home Health be ordered? ❑ Yes ❑ No

PPD/TB test or Chest XRAY performed: ❑ No ❑ Yes Date: _____ Results: _____

ANY LIMITATIONS, BEHAVIORAL CHALLENGES OR MENTAL HEALTH ISSUES: ❑ No ❑ Yes → Auditory / Visual

Hallucinations, please explain: _____

Mental Health DX: ❑ No ❑ Yes → Describe: _____

Medication / Treatment Compliant: ❑ Yes ❑ No Forgetful: ❑ Yes ❑ No Cognitive Impairment: ❑ Yes ❑ No

Registered Sex Offender: ❑ No ❑ Yes please explain: _____

Requires oxygen: ❑ Yes ❑ No – Able to Self-Administer All Meds: ❑ Yes ❑ No → explain: _____

Bowel or Bladder Incontinent: ❑ Yes ❑ No – Colostomy / Ileostomy: ❑ Yes ❑ No Foley Catheter: ❑ Yes ❑ No

Independent with all ADL's: ❑ No ❑ Yes please explain: _____

Diabetic: ❑ No ❑ Yes → ❑ Insulin: _____ ❑ Oral Meds: _____

Communicable Diseases: ❑ No ❑ Yes please explain: _____

Anticoagulants: ❑ No ❑ Yes please explain: _____

Requires INR/PT/PTT checks through Home Health or Clinic ❑ No ❑ Yes please explain: _____

Ambulatory: ❑ Yes ❑ No – Assistive device: ❑ No ❑ Yes please explain: _____

Does Patient have a car: ❑ Yes ❑ No Spouse/Partner: ❑ Yes ❑ No Service Animal: ❑ Yes ❑ No

Length of Stay authorized in Recuperative Care: _____ days

Attach: ❑ Face-Sheet ❑ H&P ❑ Med List ❑ Psych note ❑ Surgical notes ❑ PT/OT Eval. ❑ SW notes ❑ Chest X-ray

Ft KNOX - *REFERRAL COORDINATOR* - ONLY

Date Received: _____ Reviewed by: _____ Approved: ❑ Yes ❑ No Auth. No: _____

Denial Reason: _____ Admission Date/time: _____ Exit Date: _____

Extension Requested: ❑ No ❑ Yes → Approved additional days: _____ by: _____ TOTAL LOS: _____