

TB and Covid testing to be completed within 48-72 hours of admission to Room in the Inn

Attached H&P Yes <input type="checkbox"/> No <input type="checkbox"/>	Attached Negative TB Test Yes <input type="checkbox"/> No <input type="checkbox"/>	Attached Admission Note Yes <input type="checkbox"/> No <input type="checkbox"/>	Attached Other: Yes <input type="checkbox"/> No <input type="checkbox"/>
Attached Discharge Medicine List Yes <input type="checkbox"/> No <input type="checkbox"/>	Attached Psychiatric Notes (If Applicable) Yes <input type="checkbox"/> No <input type="checkbox"/>	Attached Negative Covid-19 Test Yes <input type="checkbox"/> No <input type="checkbox"/>	<hr/> <hr/> <hr/>

Will you be filling prescriptions for this person? Yes No If so, include 30 day supply of medications.

Will the patient be coming with any controlled substances? Yes No

Patients Name: _____ Date of Birth: _____

SSN: _____ Sex: _____ Phone: _____

Race (please select all that apply): American Indian/Alaska Native Asian

Black/African American Native Hawaiian/Pacific Islander White

Hispanic/Latino: Yes No Has the patient ever served in the military? Yes No

Emergency Contact Name: _____ Phone Number: _____

Where was the patient living before admittance? _____

Does the patient have any income? If so, what is the source & amount? _____

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

What is the patient's plan for what they will do once their recuperative care stay is up?

Acute medical problem: _____

Secondary diagnosis: _____

Psychiatric diagnosis: _____

Addictions- 5 days or more preferred of Active Detox:

Does the patient require assistance with any ADLs (toileting, dressing, transfers, etc.)? Yes No

Is the patient ambulatory? Yes No

Assistive device needed? Yes No If so, please initiate during hospital stay and forward DME company info

Follow up appointment day, time and place: _____

Please be specific. Give address and phone number.

Referred by: _____ Phone: _____ Pager: _____

Hospital/Department: _____

Email: _____

Is the patient oriented to person, place, and time? Yes No

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

MEDICAL PATIENTS
Does the patient have any contagious illness or have been in isolation? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, describe: _____ _____
Does the patient have any type of lice or scabies? Yes <input type="checkbox"/> No <input type="checkbox"/>
If there was an infection, has it cleared? Yes <input type="checkbox"/> No <input type="checkbox"/>
Did this person have diarrhea in the hospital? Yes <input type="checkbox"/> No <input type="checkbox"/> If so, is it controlled now? Yes <input type="checkbox"/> No <input type="checkbox"/>
Medical supplies needed for patient care: If so, please order prior discharge. _____
Hospital supplied? Yes <input type="checkbox"/> No <input type="checkbox"/>
What is the pain management plan for this patient? _____

SURGICAL PATIENTS
If there was an infection, has it cleared? Yes <input type="checkbox"/> No <input type="checkbox"/>
Did this person have a heart related procedure? Yes <input type="checkbox"/> No <input type="checkbox"/>
Will this person need home healthcare? Yes <input type="checkbox"/> No <input type="checkbox"/> If so, agent: _____ Phone: _____
Will this person need physical therapy? Yes <input type="checkbox"/> No <input type="checkbox"/> If these services are needed, they must be arranged prior to discharge to recuperative care.
Medical supplies needed for patient care: _____
Hospital supplied? Yes <input type="checkbox"/> No <input type="checkbox"/>
What is the pain management plan for this patient? _____

Will this patient have a urinary catheter? Yes No Will the patient have an ostomy bag? Yes No

Is this a patient continent of bowel and bladder? Yes No Is the patient dealing with cancer? Yes No

If so, in what stage are they? _____ Is the patient aware? Yes No

Notification of Privacy Rights We collect personal information about you to improve our services for you. We are required by law and organizations that fund us to collect and share certain personal information. Some of the information you provide will be entered into a Memphis-area database accessible by public agencies and departments in Memphis in an effort to coordinate and improve city-wide services in the future. This information includes your name, gender, date of birth, Social Security Number, veteran status, ethnicity, race, and whether you have a disabling condition (the condition will not be listed). Individually identifiable health information will not be entered into the database. As required by law, the database will be protected by appropriate security measures and will only be accessible to authorized Memphis database users and as otherwise required by applicable law.

Your eligibility to receive services from Room In The Inn will not be conditioned on whether you sign this consent. You may choose not to sign this consent. You can revoke your consent at any time. However, your revocation will not be effective to the extent that we have already acted in reliance on your consent.

The information that I have given on this form is correct to the best of my knowledge. I have read the above "Notification of Data Disclosure and Privacy Rights." By signing below, I expressly authorize and consent to Room In The

Inn-Memphis providing my personal information to the Memphis-area database accessible by Memphis authorized users.

***Please Note: Referrals cannot be processed unless completed in full by the referral source and signed by the patient.**

I give permission for the information on this recuperative care referral form to be shared with Room In The Inn.

Patient Signature

Date

Hospital