ROOM IN THE INN MEMPHIS
RECUPERATIVE CARE CENTER

Recuperative Care Referral Form

P: 901-467-0122 E: RCC@ritimemphis.org

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

Attached H&P **Yes ▢ No ▢**	**Attached Negative TB Test** **Yes ▢ No ▢**	**Attached Admission Note** **Yes ▢ No ▢**	**Attached Other:** **Yes ▢ No ▢**
Attached Discharge Medicine List **Yes ▢ No ▢**	**Attached Psychiatric Notes (If Applicable)** **Yes ▢ No ▢**	**Attached Negative Covid-19 Test** **Yes ▢ No ▢**	_____ _____ _____

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 ▢ No ▢ If yes, describe:_____
_____

Does the patient have any type of lice or scabies?
Yes ▢ No ▢

If there was an infection, has it cleared? Yes ▢ No ▢

Did this person have diarrhea in the hospital? Yes ▢ No ▢

If so, is it controlled now? Yes ▢ No ▢

Medical supplies needed for patient care: If so, please order prior discharge._____

Hospital supplied? Yes ▢ No ▢

What is the pain management plan for this patient?

_____

SURGICAL PATIENTS

If there was an infection, has it cleared?
Yes ▢ No ▢

Did this person have a heart related procedure?
Yes ▢ No ▢

Will this person need home healthcare? Yes ▢ No ▢

If so, agent:_____

Phone: _____

Will this person need physical therapy? Yes ▢ No ▢
If these services are needed, they must be arranged prior to discharge to recuperative care.

Medical supplies needed for patient care:

_____

Hospital supplied? Yes ▢ No ▢

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 ▢

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

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.

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

_____	_____	_____
Patient Signature	**Date**	**Hospital**