RIS Foundation Recuperative Care: Referral Form

Contact: Angelica@risfoundation.org or FrontDesk@risfoundation.org Fax: (323) 967-4240 |

24 Hour/ 7 Days a Week Risfoundation.org

<table>
<tr><td>Patient Name:
Last:
____
First:
____
Patient Contact Number:</td><td colspan="2">DOB:
___/____/_____
_ Gender:
____
Preferred Pronoun:
______</td><td>How Many Days is Patient Auth. at Recuperative Care?
___ 10 ___15 ___20
___30___45___60</td></tr>
<tr><td colspan="4">Referring Hospital/Facility:</td></tr>
<tr><td>Date of Referral:</td><td colspan="3">Referring Party Name:

Title:</td></tr>
<tr><td colspan="4">Phone # & Email for referring party:
( ) -</td></tr>
<tr><td colspan="2">Next of Kin/Emergency contact Name:</td><td colspan="2">Next of Kin Phone Number:</td></tr>
<tr><td>Type of Insurance</td><td colspan="2">SSN#:</td><td>Patient can self-administer medications? Yes___
No___</td></tr>
<tr><td>Insurance #</td><td colspan="3">Primary Language:</td></tr>
<tr><td>___ Dangerous Risk & Behaviors:
___ Physical Aggression
___ Mental Health Diagnosis
___ Inappropriate sexual behavior
___ Patient has wounds?
___ Patient need Home Health
Other:
__________________________</td><td colspan="3">___ Suicide Risk
___ Alcohol or Illegal substance use ___ Active TB or MRSA?
___ Patient is on Isolation
Why?
_______________________________ ___
Additional Concerns Not Listed: ___
Please List_____________________</td></tr>
</table>

RIS Foundation Recuperative Care: Referral Form

Contact: Angelica@risfoundation.org or FrontDesk@risfoundation.org Fax: (323) 967-4240 |

24 Hour/ 7 Days a Week Risfoundation.org

Reason for most recent hospitalization: (Please describe illness, injury, or wounds and other relevant information that can help us help the patient)
Has Prescription been provided? Yes___ No___ Current Medication/dosage/frequency:
Any food or medication allergies or dietary restrictions: Yes___ No___
Independent with ADL's? Yes____ No_____ (if not, please explain limitations) DME devices used:
Additional Comments:
Were ALL Criteria from Admission Criteria Met? Yes____ No_____ If not, please explain:
All information is correct and hospital agrees to terms of referral Yes___ No___ Signature of Referring Party: Date / /