



# Recuperative Care Referral Form

705 Drexel Street, Nashville, TN 37203  
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More information and admission criteria are available at [roomintheinn.org/recuperativecare](http://roomintheinn.org/recuperativecare).

Attached H&P and Admission Note? Yes  No

Attached Discharge Medicine List: Yes  No

Will you be filling prescriptions for this person? Yes  No

Will the patient be coming with any narcotics? Yes  No

*Please note that we partner with the Dispensary of Hope to fill prescriptions. There is a 24-hour turn around.*

Patients Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

SSN: \_\_\_\_\_ Sex: \_\_\_\_\_ Veteran: Yes  No

Where was the patient living before admittance? \_\_\_\_\_

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

Does 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?  
\_\_\_\_\_

Has this patient been cleared by your MDs to come to recuperative care? Yes  No

Acute medical problem: \_\_\_\_\_

Secondary diagnosis: \_\_\_\_\_

Recommended length of stay: 3 days  10 days  14 days

Notes: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is the patient ambulatory? Yes  No

Does he or she need any assistive device to ambulate safely? If so, what? \_\_\_\_\_

Date of last TB test: \_\_\_\_\_ Results: \_\_\_\_\_ Treatment given: \_\_\_\_\_

Psychiatric diagnosis: \_\_\_\_\_ Treatment: \_\_\_\_\_

Does the patient have alcohol or drug addiction? Yes  No

Follow up appointment day, time and place: \_\_\_\_\_  
*Please be specific. Give address and phone number.*

Referred by: \_\_\_\_\_ Phone: \_\_\_\_\_ Pager: \_\_\_\_\_

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

### MEDICAL PATIENTS

Does the patient have any contagious illness?

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:

\_\_\_\_\_  
\_\_\_\_\_

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 health care? 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 catheter? Yes  No

Will the patient have a colostomy bag? Yes  No

Is the patient dealing with cancer? Yes  No

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

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

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Hospital



Client Intake	
Collected By	_____
Date Collected	_____
Entered By	_____
Date Entered	_____

## Basic Client Information

Complete the client's identifying information.

First Name: \* \_\_\_\_\_

Last Name: \* \_\_\_\_\_

Middle Name: \_\_\_\_\_

Suffix: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

SSN Quality: \*  Don't Know or Don't Have  Refused

## Basic Client Demographics

Birth Date: \_\_\_\_\_

Date of Birth Quality: \*  Full DOB Reported  Approximate or Partial DOB Reported  Don't Know  
 Refused

Ethnicity: \*  Hispanic/Latino  
 Non-Hispanic/Latino  
 Don't Know  
 Refused

Race: \*  American Indian or Alaska Native  
 Asian  
 Black or African American  
 Native Hawaiian or Other Pacific Islander  
 White  
 Don't Know

Gender: \*  Male  
 Female  
 Transgendered Female to Male  
 Transgendered Male to Female  
 Other  
 Don't Know  
 Refused

## Family Information

Relationship to Head of Household: \*  Self

- |                                   |  |  |
|-----------------------------------|--|--|
| <input type="checkbox"/> Parent   | <input type="checkbox"/> Dependent Child | <input type="checkbox"/> Spouse              |
| <input type="checkbox"/> Son      | <input type="checkbox"/> Grandparent     | <input type="checkbox"/> Other Family Member |
| <input type="checkbox"/> Daughter | <input type="checkbox"/> Guardian        | <input type="checkbox"/> Other Non-Family    |
|                                   |  | <input type="checkbox"/> Other Caretaker     |

*Form continues on back*



Client Information Continued

Veteran?  Yes  No

Do you receive veteran benefits?  Yes  No

Medical Problems: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_

Emergency Contact Phone Number \_\_\_\_\_

Have you been to the Winter Shelter before?  Yes  No

Do you currently use or plan to use our Mail Services?  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 Nashville area database in an effort to coordinate and improve local services in the future. This information includes 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 many layers of security and will only be accessible to authorized Nashville database users and as otherwise required by applicable law. Your eligibility to receive services from Room The In Inn will not be conditioned on whether you 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. For more information regarding the privacy of your personal information, please see the "Room In The Inn Notice of Privacy Practices," available at the Room In The Inn front desk.

The information that I have given on this form is correct to the best of my knowledge. I have read the above "Notification of Privacy Rights," and a copy of the "Room In The Inn Notice of Privacy Practices" has been made available to me. I expressly authorize and consent to my personal information being entered into the Nashville area database.

Signature: \_\_\_\_\_

Orientation	Date Completed	Orientation	Date Completed
Day Time	_____	Guest House-Emergency	_____
Winter Shelter	_____	Guest House-Transitional	_____