1. Review the admission criteria on this referral form.
2. Fax referral form, signed release to the Delonis Center: **1-734-996-3022**
3. **Text or Call 734-489-9112** to notify the RCC Outreach Coordinator that referral form has been faxed
4. RCC will contact you with questions, approval or request additional documentation
5. If you would like to discuss RCC Referral or are not receiving a timely response, please contact Front Desk at 734-662-2829 x254
6. Call **734-961-1999** for HAWC referral and mention Recuperative Care Center

COMMON RECUPERATIVE CARE CLIENT CONDITIONS

- Post surgical procedures
- Cancer
- Wound Care
- Diabetes management
- Uncontrolled hypertension
- Amputations
- Other health concerns

SAWC RECUPERATIVE CARE CENTER REFERRAL FORM

Referring Partner: SJ Chelsea SJMHS UMHS Other: _____

Name of person referring: _____

Contact #:_____ Email:_____

Secondary Contact: _____

Contact #:_____ Email:_____

Patient Name:_____ Gender: _____ DOB_____

Height_____ Weight_____Floor/Unit #:_____

Your facility's unique patient ID number: _____

Diagnosis/Condition requiring RCC stay: _____

_____

Proposed Discharge Date: _____ Proposed Discharge Time_____

Projected length of stay in the RCC _____

Is client willing to come to Delonis Center and meet with onsite Nurses Mon-Fri?: Y / N

Primary Care Physician_____ Phone_____

Is the patient connected with a Mental Health Provider? Y / N If Yes, Provider:_____

Case Manager Name: _____

Will the patient require an interpreter and if so to what language?: Y/N _____

Will the patient require pain management after discharge? Y/N

ADMISSION CRITERIA- CHECK BOXES BELOW

(must meet all criteria)

- ☐ Experiencing homelessness
- ☐ Medical issue that would benefit from RCC stay
- ☐ Independent in ADL's or adequate supports
- ☐ Independent in mobility (wheelchair or assistive device are of course accepted
- ☐ Continent of urine and feces
- ☐ Has not received benzodiazepines for alcohol withdrawal in past 24 hours
- ☐ Diabetics independent and have supplies or would benefit from education and training.
- ☐ No active communicable disease such as the flu, MRSA, VRE etc. (no isolation is possible in the shelter)
- ☐ Behaviorally appropriate for group setting (including no known suicidal or assaultive risks)
- ☐ No intravascular lines or Home Health nursing will be arranged
- ☐ Has an identifiable end date of care for discharge from the RCC
- ☐ Does not need skilled nursing care unless it can be provided by Home Help nurse
- ☐ Patient agrees to RCC admission
- ☐ If patient uses alcohol or substances they will be willing to abstain while on premises.

Program Outcome Evaluation- Required Information

Please provide emergency department and inpatient patient history according to electronic health records. SAWC plans to evaluate health improvement including potential reduction in readmission and the use of ED services for recuperative care program participants with this information.

_____ Total # of emergency department visits within 6 months from RCC referral

_____ Total # of hospital admissions within 6 months from RCC referral

ETOH:	Yes	No	Allergies: _____	Extremity	Wt. Bearing
H/O ETOH SZ:	Yes	No	Diet: _____	RLE	Full
H/O DT's:	Yes	No		LLE	WBAT
Drugs:	Yes	No	Psych DX: _____	RUE	TTWB
				LUE	NWB

Last Vital Signs: T max: _____ BP: _____ HR: _____ RR: _____ RA O2 Sat: _____

RA O2 Sat with 250 ft ambulation (required for pts with acute/chronic pulmonary processes)

CURRENT & PAST MEDICAL PROBLEM LIST

MEDICATION DOSES & SCHEDULE (or fax D/C med form)

SPECIAL TREATMENTS: (i.e. monitoring, activity restrictions)

FOLLOW UP: (Please include clinic, appointment date, and time. **List visiting nursing information and schedule if applicable. If client requires wound care, please set up Home Health Nursing and share schedule.)**

Please notify hospital that if we are able to accept the patient they must provide patients discharged to recuperative care with:

- 30 Day supply of all necessary medication unless a shorter course of administration is recommended, or other arrangements are made with the RCC Program Director. Please use Genoa Pharmacy for filling new prescriptions so the client may have prescriptions delivered to the Delonis Center.
- An assistive device for ambulation if prescribed by referring facility.
- Medical supplies for the patient (type/amount to be determined by patient need/condition) through Home Health Care.
- HAWC Referral by calling 734-961-1999 with the client

Signature: _____ Date: _____