



Laguna Honda Hospital and Rehabilitation Center

375 Laguna Honda Blvd San Francisco CA 94116

Admissions Department

Referral Form

FAX back to (415) 759-3012

Admissions (415) 759-4670

For best assessment and appropriate decision, referral form must be filled out completely. Parts A, B, C may be completed by physician or social worker or family member or hospital discharge planner or representative of community agency. Only physician or other clinician may complete Part D.

NAME of patient _____
Last, First

PART A

Requested Placement

General SNF (M5) SNF Rehab (L4S) Acute Rehab (L4A) Hospice/Palliative

AIDS (O4) Psychosocial Respite, Dates _____

Prior Living Arrangments _____

Referring Facility _____ Date of Referral _____

Discharge Planner _____

Phone # _____ Pager # _____

Physician _____

Phone # _____ Pager # _____

Additional Contact _____

Phone # _____ Pager # _____

Do any of the following exclusion factors apply to the person being referred:

- Communicable disease (LHH may not have appropriate isolation quarters) Yes No
- Person under police hold (24-hour guard may be required by sheriff's Dept) Yes No
- Mental Illness or developmental disability requiring an organized program of active psychiatric intervention, according to Title A of the California Administrative Code, paragraph 278.2(1), (b), (c) Yes No
- Needs some type of chemotherapy (LHH cannot provide all types) Yes No

Patient's Name _____

- Ventilator dependent Yes No
- TPN (total parenteral nutrition) Yes No
- Active medical problem requiring ICU care Yes No
- Primary psychiatric diagnosis without coexisting dementia or other medical diagnosis appropriate for SNF care Yes No

Patient's current level of Care: (if in SNF now, please also indicate acute dates)

 SNF Acute Acute Rehab Home Board & Care

SNF Dates _____ Acute Dates _____

Please confirm that the person being referred meets basic admission criteria

- Resident of City & County of San Francisco Yes No
- Primary diagnosis is a medical condition (not psychiatric) requiring skilled nursing facility care (MD verified) Yes No
- Existing physical or cognitive functional limitations requiring care that cannot be provided at a lower level (e.g. B&C, intermediate facility) Yes No
- Requires active daily rehabilitation on an inpatient basis Yes No
- Need for ongoing rehabilitation aimed at improving functional status Yes No

PART B

Section 1 Patient Demographics

Name of Patient _____ Age _____

Birthdate _____ Sex _____ Race _____ Ethnicity _____

Address _____ City _____

State _____ Zip Code _____ Phone _____

Marital Status _____ Occupation _____

SS# _____ Birthplace _____

Primary Language _____ English Speaking Yes NoReligion _____ Smoker Yes No

Nearest Relative _____ Relationship _____

Relative's Address _____ Phone _____

Emergency Contact _____ Phone _____

Patient's Name _____

Is patient conserved? Yes No If yes, what type _____

Name of conservator _____ Phone _____

Patient's Last Name _____

Section 2 Pre-Admission Financial Data

A. Government Benefits

Medicare: Part A effective date _____ Eligible Yes No
 Part B effective date _____ Number _____
 Part D, prescription Rx plan _____

Medi-Cal:
 Eligible Yes No
 Number _____ Effective Date _____
 Pending, Application Date _____
 Approved/effective Date _____

B. Private Insurance/HMO

Carrier Name _____ Policy/Group # _____
 Contact and Phone # _____
 Name of Insured _____ Union/Local (if applicable) _____

C. Income

Monthly Amount \$ _____ Source _____
 Monthly Amount \$ _____ Source _____
 Other (describe) _____

D. Assets

Cash on hand \$ _____ Bank Funds \$ _____
 Acct. Type(s) _____
 Bank(s) _____
 Securities (current value) _____
 Property:
 Location _____
 Assessed Value _____ Amount Owed _____
 Other (describe) _____

PART C

Section 1 Medical Diagnosis/SNF Need

Diagnosis requiring SNF level of care: _____

Allergies _____

PICC _____

Wounds _____

Dressing Frequency _____

NGT/PEG/ J-tube Yes No Weight _____ Height _____

Special Equipment (e.g. CPAP, BiPAP, wound vac, etc): _____

Does he/she have own equipment and self-manages it outside acute care? _____

IV Antibiotics _____ Duration _____

Date last PPD _____ Results _____

Date last CXR _____ Results _____

Advance Directive or
Code Status: Full Code DNR/DNI Comfort Undetermined

Infections: VRE MRSA TB +PPD None

Where? _____

Treatment _____

Immunizations: pneumococcal vaccine Yes, Date _____ No

Influenza vaccine Yes, Date _____ No

Other: _____ Date _____

Section 2 Activities of Daily Living

Indicate appropriate Number next to activity

- 1= independent _____ walking
- 2= assist with device _____ turning/positioning
- 3=assist with person _____ transferring
- 4=assist with person and device _____ bathing _____ dressing
- 5= totally dependent _____ feeding _____ toileting

Indicate Status:

- Bowel: incontinent continent Bladder: incontinent continent
 colostomy Foley catheter or suprapubic tube

Diet: _____

Section 3 Behavioral Issues

- 1. Criminal Hx: Yes No
- 2. Possession/Use of weapons, illegal drugs or drug paraphernalia, drug trafficking? Yes No

Answer # 3, 4, 5, 6, 7 based upon behavior over the past 10 days:

- 3. Aggressive/Assaultive/Combative: Yes No
- 4. Intrusive Behavior: Yes No
- 5. Noisy/Disruptive: Yes No
- 6. Elopement Risk Yes No
- 7. Is patient dangerous to self or others Yes No
- 8. Psychiatric Condition: Yes No
Dx _____
- 9. Suicidal Ideation Yes No
Presently Yes No
In the past Yes No
- 10. Sexual Predation Yes No
Registered sex offender Yes No

If yes to any above, state # and describe _____

11. Alcohol History: _____

12. Drug Abuse: Yes, type _____ No
 Currently using (at time of hospitalization): Yes No
 Past use: Yes No

13. Is patient on restraints? Yes, Type _____ No

14. Smoking History: _____

15. Unsafe smoker? Yes No

16. Does patient have a sitter? Yes, Reason _____ No

17. Are there (past or present) any legal charges for any above behaviors? Yes No

 If yes, describe _____

PART D

Medical Information Summary

1. *For referrals from BOARD & CARE FACILITIES and HOME, this portion must be completed by a physician or other clinician to assure accuracy and meet legal compliance.*
2. *For referral from ACUTE HOSPITALS or OTHER HEALTHCARE FACILITIES, in lieu of completing this section, you must submit the following:*
 - Recent 1 week of nursing notes and progress notes
 - Complete medications list
 - Most recent history & physical
 - If rehab referral, most recent PT and OT notes

Please check which items above have been attached in lieu of completing Part D

Signature required whether Part D is completed or attachments are provided.

Patient Name _____

Primary Physician _____ (print name) Phone # _____

Physician Signature _____

Alternate Contact Person _____ Phone # _____

Active Medical Problems:

Summary of Problems: _____

Past Medical History: _____

Patient's Last name _____

Previous Surgeries (Dates and location):

_____	_____
_____	_____
_____	_____

Disabilities (include sight, hearing, ambulation)

Current Medications:

Date of last physical and relevant findings:
