HOLA Recuperative Care: Referral Form

Contact: Kelly@RecuperativeCare.Org or FrontDesk@RecuperativeCare.Org

Fax: (661) 424-7347 | 24 Hour Hot Line: (866) 990-2578 | www.RecuperativeCare.org

Patient Name: Last: _____ First: _____ Patient Contact Number:	DOB: ___/____/_____ Gender: _____ Preferred Pronoun: _____	How Many Days is Patient Auth. at Recuperative Care? ___ 10 ___15 ___20 ___30___45___60
Referring Hospital/Facility:		
Date of Referral:	Referring Party Name: Title:	
Phone # & Email for referring party: ( ) -		
Next of Kin/Emergency contact Name:	Next of Kin Phone Number:	
Type of Insurance	SSN#:	Patient can self-administer medications? Yes___ No___
Insurance #	Primary Language:	
___ Dangerous Risk & Behaviors: ___ Physical Aggression ___ Mental Health Diagnosis ___ Inappropriate sexual behavior ___ Patient has wounds? ___ Patient need Home Health Other: _____	___ Suicide Risk ___ Alcohol or Illegal substance use ___ Active TB or MRSA? ___ Patient is on Isolation Why? _____ ___ Additional Concerns Not Listed: ___ Please List_____	

HOLA Recuperative Care: Referral Form

Contact: Kelly@RecuperativeCare.Org or FrontDesk@RecuperativeCare.Org

Fax: (661) 424-7347 | 24 Hour Hot Line: (866) 990-2578 | www.RecuperativeCare.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 / /**