COLARC PATIENT INTAKE/REFFERAL FORM

WE WILL REQUIRE THE FOLLOWING TO REVIEW:

1) Completed Referral/Intake Form
2) DC Summary with Face sheet, H&P, Medication List, and Any Other Supporting Clinical Documents

Fax to and/or Email

Fax: (818) 696-8004
Email: admissions@colarc.org

Patient Name **Last:** **First:**		**DOB:**	**Gender:** ☐ M ☐ F ☐ OTHER
SSN: ___ ___	**Race:**	**SSI Status:** ☐ Pending ☐ Has Not Applied ☐ Unknown	
Insurance:	**Primary Language:**		
Date of Referral:	**Anticipated DC Date:**	**Referring Hospital:**	
Referring CM/SW:	**Phone:**	**Email:**	
Date of Admission:	**Hospital LOS:** _____ days	**Any Wounds?** ☐ Y ☐ N	**If yes, List What Stage:**

Any Surgical Procedures During Hospitalization?
If yes, please describe:

Reason for Admission/Visit:

Will Patient Need Home Health? If yes, check all that applies:
☐ Wound Care ☐ IV Antibiotics ☐ PT ☐ OT ☐ ST ☐ CHHA ☐ Nursing

Will Patient Need Hospice? ☐ Y ☐ N

Has the Patient Been Cleared from All Types of Communicable Disease? ☐ Y ☐ N	**Is Patient Continent of Bowel & Bladder?** ☐ Y ☐ N	**Does Patient Require Colostomy/Ileostomy Care?** ☐ Y ☐ N	**Does Patient Have a Foley Catheter?** ☐ Y ☐ N
Independent with all ADLs? ☐ Y ☐ N	**Ambulatory?** ☐ Y ☐ N	**Assistive Device?** ☐ Y ☐ N	

If patient requires assistive device, list DME(s):

Limitations, Mental Health and Behaviors

Does Patient have Mental Illness? ☐ Y ☐ N

Is Patient on Psyche Medications? ☐ Y ☐ N

Please Check all That Applies:
☐ Bipolar ☐ Depression ☐ Schizophrenia ☐ Psychotic Disorder ☐ Other

Please List Mental/Behavioral Health Medications if Applicable:

If Applicable, Please Check:
☐ Convicted for a Sexual Crime ☐ Cognitive Impairment ☐ Arsonist
☐ Combative ☐ Non Compliant ☐ On-Probation ☐ Forgetful ☐ Other _____

Does Patient Currently Smoke Cigarettes? ☐ Y ☐ N

Substance Abuse:	**PAST USE**	**CURRENT USE**	**LAST USED**
Alcohol	☐ Y ☐ N	☐ Y ☐ N	Date: _____
Heroin	☐ Y ☐ N	☐ Y ☐ N	Date: _____
Cocaine/Crack	☐ Y ☐ N	☐ Y ☐ N	Date: _____
Meth	☐ Y ☐ N	☐ Y ☐ N	Date: _____
Other	☐ Y ☐ N	☐ Y ☐ N	Date: _____

*********REQUIRED for all patients prior to acceptance to COLARC*********

1) Must be cleared of all active communicable diseases and exclusion criteria
2) Patient must have a home health or a hospice order if patient requires home health or hospice care
3) If patient has a wound, patient must discharge with wound care supplies and wound care treatment order
4) Patient must have a minimum supply of two (2) weeks to one (1) month of psych medications and prescription refill upon discharging