Hebrew Hospital Home, Inc.
801 Co-op City Blvd., Bronx, New York 10475

# REFERRAL ASSESSMENT FORM

PRI Classification: _____

RUGs Category: _____

Managed Care Skill Level: _____

Date of assessment: _____

Hospital: _____ Floor/unit: _____

Date of admission: _____

Name: _____ Insurance: ____ MC ____ MA ____ Other: _____

Age: ____ Sex: ____ Male ____ Female ____ Height: _____ Weight: _____

DIAGNOSIS: _____

____ Cardiac rehabilitation ____ Postsurgery (wound care) ____ Pulmonary ____ Renal ____ TBI

____ Orthopedic rehabilitation ____ Complex medical ____ Neurological ____ IV antibiotics ____ Other: _____

Mental Status: _____ Psyche Hx: _____

CLINICAL COURSE: _____

_____

_____

_____

_____

_____

SPECIAL MEDS/TX (include anticoagulants, antibiotics, and inhalants): _____

_____

Special needs: ____ Private room ____ Contact isolation ____ Oxygen ____ Special DME/supplies (list): _____

Does the patient have a rehabilitation diagnosis: ____ Yes ____ No

Receiving rehabilitation: ____ Yes ____ No Motivated: ____ Yes ____ No Needs encouragement: ____ Yes ____ No

Endurance: ____ Good ____ Fair ____ Poor Weight-bearing status: _____ Assistive device: _____

ADLs (PRI score): Feeding ____ Transfers ____ Ambulation ____ Toileting ____ Foley ____ Colostomy ____

Current rehabilitation program (please check): PT ____ No. of sessions/day ____ No. of days/week ____

OT ____ No. of sessions/day ____ No. of days/week ____ ST ____ No. of sessions/day ____ No. of days/week ____

SUBACUTE rehabilitation goals: No. of sessions/day ____ Treatment plan: _____

_____

_____

DISCHARGE PLAN

Short term/subacute: ____ Long term/custodial: ____

Family contact/significant other: _____ Telephone: _____

Hospital social worker/discharge planner: _____ Telephone/pager: _____

HOSPITAL DATA NEEDED: ____ ECG ____ CXR ____ CBC/ PT/ SMAC ____ Consults ____ PT/OT/ST Notes ____

Culture reports ____ DNR ____ Advance directives ____ Other: _____

Copy of hospital face sheet attached: ____ Yes ____ No

____ ACCEPTED ____ NOT ACCEPTED ____ PENDING (reason): _____

Nurse Case Manager _____ Date _____

**HEBREW HOSPITAL HOME, INC.**
**PATIENT ASSESSMENT ADDENDUM**

**PATIENT NAME:** _____
**HOSPITAL LOCATION:** _____ **LOS:** _____
**NAME OF CONTACT (if applicable):** _____

**Does the patient have (please check):**

- ❑ Stage 3 or 4 decubiti or multiple-staged decubiti?
- ❑ Surgical wounds or open lesions?
- ❑ Foot lesions or infections?
- ❑ Feeding tube?
- ❑ Fever with dehydration, pneumonia, or vomiting?
- ❑ Coma?
- ❑ Hemiplegia?
- ❑ Dehydration?
- ❑ Pneumonia?
- ❑ Internal bleeding?
- ❑ Sepsis?
- ❑ Terminal illness?

**SPECIAL TREATMENTS AND PROCEDURES:**

**A. SPECIAL CARE: Check treatments or programs received during the last 14 days.**

**Treatments:**

1. Chemotherapy _____
2. Dialysis _____
3. Intravenous medication _____
4. Intake/output _____
5. Monitoring acute medical condition _____
6. Ostomy care _____
7. Oxygen therapy _____
8. Radiation _____
9. Suctioning _____
10. Tracheostomy _____
11. Transfusions _____
12. Ventilator or respirator _____

**B. THERAPIES:** **Day/min per session**

1. Speech: language pathology and audiology service ____ /____
2. Occupational therapy ____ /____
3. Physical therapy ____ /____
4. Respiratory therapy ____ /____

**C. PHYSICIAN VISITS:**

**In the last 14 days, how many times has the physician examined the resident?** _____

**D. PHYSICIAN ORDERS:**

**In the last 14 days, how many days has the physician changed the orders (excluding renewals)?** ____

**RN signature** _____ **Date** _____