Referral form for: LA, LBC, LVT, East LA, Torrance, and East La Percy

To refer a patient, please email to: Info@serenityrecupcare.com or fax to: 818-979-0428

Referring Hospital Please Complete All Information In ALL Sections- Incomplete referral only causes delays!!!

Referring Hospital: _____ Dept./Floor _____
SW/CM/RN: _____ Phone/pager # _____
Email: _____ Nursing stations # _____
Authorized by: _____ Phone # _____

Demographic and Medical Information

Patient Name _____ RN _____ **DOB** __/____/_____

Gender ___Male ___Female ___Transgender____ Ethnicity _____ Social **Security #** _____/____/_____

___ **ED Visit** ___**Hospital Admit Date** ____/____/_____, **Expected Discharge Date** ____/____/_____

Insurance Type: _____ English **Speaking** ____Yes ____ No Primary **Language** _____

Chief Complaint/Admitting Diagnoses _____

_____

Substance Abuse? ____None ___Alcohol ____ Cocaine ____ Heroin _____ Meth _____Xanax other _____

Last date used _____/_____/_____ Current Withdrawals ____ Yes ____ No If yes, please explain

_____

_____

Any Wounds? ___ Yes ____ No #/LOC/Size/Stage _____

Independent with would care ___ Yes ___ No If no, will Home Health be ordered ___ Yes ___ No

PPD/TB test performed ____ Yes ____ No Date: ___/___/_____ Results _____

Limitations, Behavioral, and Mental Health Concerns

Mental Health Dx: If yes type: _____ ____ Non-compliant
____Forgetful ____Cognitive Impairment ____Registered Sex Offender ____

Other, please explain _____

Basic Patient Needs

Requires O2? ___ Yes **___** No **Self-Administer Meds? ___**Yes ___ No Please explain _____

Continent of bowel and bladder ___ Yes ___No Colostomy/**Ileostomy** ___Yes ___ No

Foley Catheter ___ Yes ___ No Independent **with all ADLs** ___ Yes ____ No Please explain
_____

Diabetic: ___ Yes ___ No then ___ Insulin ____ Oral Meds

Communicable Diseases? ___ Yes ___ No Please describe _____

Anticoagulants? ___ Yes ___No Require INR/PT/PIT checks through Home Health or Clinic? _____

Ambulatory? ___ Yes ___ No Assistive **device** ___ Yes ___ No Please explain _____

Does Patient have a caretaker?: ___ Yes ___ No **Spousal/Partner ____** Yes ___ No **Service Animal** ___ Yes ___ No Please give details: _____

How many days is patient authorized to stay at Serenity Recuperative Care? _____ days /months

Serenity Staff Only

Attached Documents: ____ Hospital Face Sheet _____ H&P ____ Med List ___ Psych Notes ____ Surgical Notes ____ PT/OT Evaluation

Date Received documents ____/___/_____ Admission Date and Time ____/____/_____ Time: _____:____

Extension Requested ___ Yes ____ No If yes, approved additional days_____

Approved by: _____

TOTAL LOS: _____