MEDICAL RESPITE CARE PROGRAM
Respite Request and Referral Form
REFERRAL LINE: 720-422-5938: FAX: 303-296-1306

All requests for respite beds must be approved by the Respite Manager (or designee).

SAMARITAN HOUSE:	2301 Lawrence St, Denver 80205	Phone: 303-294-0241	Fax: 303-296-1306
BEACON PLACE:	3636 West Colfax, Denver 80204	Phone: 303-629-1667	Fax: 303-629-0372

Date: ___________________________ Requested length of stay? ___________ days _________weeks

Patient Name: ___________________________________ DOB: _________________ SSN: ______________________

Medicaid # __________________________ Medicare # ________________________________

Any ETOH use in the last 72 hours? ❑Yes ❑No
Is the client on parole? ❑Yes ❑No
Is the client on probation? ❑Yes ❑No
Offense__________________________

Has the client **EVER** been:
Convicted of a sex offense? ❑Yes ❑No
Convicted of a violent crime? ❑Yes ❑No
Offense ____________________

Primary (acute) diagnosis, including ICD-10: ____

Other diagnoses, acute and chronic, for this patient: ______________________________________

Any Infectious Disease? ❑Yes ❑No If yes, indicate which: ❑HEP C ❑HIV ❑MRSA ❑VRE
Mental Health diagnoses? ❑Yes ❑No Diagnosis: ______________________________________
MH Medication? ❑Yes ❑No List Meds: ______________________________________
Mental Health Provider: ❑Yes ❑No Provider: ______________________________________

Current Level Of Function

Performs all ADLs independently? ❑Yes ❑No
Alert/Oriented X 3? ❑Yes ❑No
Continent of bowel and bladder? ❑Yes ❑No
Can take meds without help? ❑Yes ❑No

❑Yes ❑No Current discharge medication list attached ❑Yes ❑No Current H&P attached (ACS + Chart Note)

❑Yes ❑No Current Labs – Discharge Summary

Does client have minimum of 1 week supply of ALL medications? ❑Yes ❑No ________________________
Does client use oxygen? ❑Yes ❑No Company:____________Oxygen provider contacted to transfer? ❑Yes ❑No
Does client need wound care? ❑Yes ❑No If yes, see wound care referral and guidelines on pages 2 and 3.

Client's follow-up appointments: Please be specific.

Name of regular Provider/PCP ______________________________ Denver Health Provider? ❑Yes ❑No

Specialty Care Appointments (Dates & clinics): ____

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Has the client applied/has disability? ❑Yes ❑No_________ Has the client applied/has Medicaid? ❑Yes ❑No________

Requesting Provider _______________________________ Provider Signature __________________________________

Referring Case Manager ___________________________ Referring CM Signature ______________________________

CM Phone Number _________________________________ CM Fax Number ____________________________________

Referring Facility ___________________________________

Revised 01/04/2015