COLORADO COALITION FOR THE Homeless Creating, Leading, Lasting

COVID-19 RESPONSE| ACTIVATED RESPITE CARE BRIDGE HOUSING PROGRAM

Send all referrals via email to: **activatedrespite@coloradocoalition.org**

After 5pm weekdays or anytime on weekends, call 303-312-9800 to confirm receipt of referral

All referrals must be approved by Colorado Coalition for the Homeless Staff prior to intake

1. **Today's Date:** _____ **Patient Full Name:** _____ **DOB:** _____
SSN: _____ **Medicaid/Medicare #** _____ **Patient Phone #**_____

2. **Is this a COVID-19 related referral?** ☐ Yes ☐ No | **Has Patient been tested yet:** ☐ Yes ☐ No **Date of Test:** _____

Anticipated Result Return Date: ____Testing Follow Up Plan_____ COVID Follow Up Contact Information_____

If Yes: Please list current symptoms r/t positive or negative results? _____

Does this patient have the following risk factors?

- ☐ Diabetes
- ☐ Chronic Heart Disease
- ☐ Chronic Lung Disease
- ☐ Chronic Kidney Disease
- ☐ Immunosuppressive
- ☐ Respiratory illness
- ☐ Contact w/ positive test individual
- ☐ Above the age of 60
- ☐ Other _____

3. Please list patient's acute or chronic medical and psychiatric needs for potential Respite support:

_____

4. **Does this patient have…**
   - Acute Withdrawal Concern Currently? ☐ Yes ☐ No | Details: _____
   - Psychiatric or behavioral health needs? ☐ Yes ☐ No | Details: _____
   - Isolation Requirements, R/T COVID or other infectious disease? ☐ Yes ☐ No | Details: _____
   - Have minimum of 48-hour supply of ALL medications? ☐ Yes ☐ No ***Note we cannot accept someone without this**
   - Does client need or use oxygen? ☐ Yes ☐ No ***Note: Oxygen needs to coordinated by hospital before discharge.**
   - Does client need wound care? ☐ Yes ☐ No ***Note: If yes, send wound care instructions and pictures if able. Patient must be able to do own wound care or wound must be manageable with minimal nursing support.**
   - Does Patient understand that CCH will provide the patient's medical and nursing care during stay?
     ☐ Yes ☐ No Details: _____
   - Does Patient understand that CCH is not able to provide transitional housing options at discharge?
     ☐ Yes ☐ No Details: _____

5. **Current Level of Function:** ***If answer is no for any of the below, the patient is not eligible. Please ensure accuracy.***
   Performs all ADLs 100% independently? ☐ Yes ☐ No
   Can take medications independently? ☐ Yes ☐ No
   Alert & Oriented X 3? ☐ Yes ☐ No
   Continent of bowel and bladder ☐ Yes ☐ No

6. **Additional Information**:
   - Dietary Needs? ☐ Yes ☐ No | Details: _____ Service animal or Pets? ☐ Yes ☐ No | Details: _____
   - Can patient walk up/down a flight of stairs without assistance? ☐ Yes ☐ No | Details: _____
   - Does patient use any assistive device(s) for ambulation? ☐ Yes ☐ No | Details: _____
   - Does patient have a BMI greater than 37? ☐ Yes ☐ No | Details: _____

Please provide accurate information for direct communication within 30 minutes. Please include Last Physician Progress Note

Requesting Provider or Social Worker: _____ **Direct!** Contact Number: _____

Referring Facility: _____ **Direct!** Contact Email Address: _____

Is this facility in Denver: ☐ Yes ☐ No | If No, was this patient transported to you by Denver Health Paramedics? ☐ Yes ☐ No

Patient agrees to have their information shared to coordinate services? ☐ Yes ☐ No