Buena Vista
REGIONAL MEDICAL CENTER

Referring Facility: _____

Contact Person: _____

Phone: _____

Fax: _____

Hope Harbor Admission Process:

IN ORDER TO EXPEDITE THE ADMISSION PROCESS, ALL OF THE FOLLOWING INFORMATION MUST BE COMPLETED AND FAXED TO HOPE HARBOR (ALONG WITH THIS SIGNED LIST). PLEASE WAIT UNTIL ALL INFORMATION IS COLLECTED PRIOR TO FAXING (712-213-4034).

1. *Copy of **complete** History and Physical **within the past 6 months.***
2. *Recent lab work, CBC, BMP and UA-within 2 weeks prior to admission. **The H&P and lab work will be reviewed by our medical director to determine if patient is medical stable and meets criteria for admit.***
3. *Complete form list of attempted medical and non-medical interventions used, dates and outcomes for the past few days. **This is essential. Please do NOT send pages of nursing progress notes.***
4. *List of current medications/MAR*
5. *Demographic information/Face Sheet*
6. *Signed consent to return to the facility. **This must be signed by a DON and/or Administrator of the facility.***
7. *Copy of front and back of updated Medicare and other insurance cards.*
8. *Copy of Advanced Directives-Medical Power of Attorney, Living Will, etc.*
9. *Copy of Code Status.*
10. *Copy of court committal papers, if applicable.*
11. *Copy of Social History, if available.*
12. *Copy of psychiatrist notes/evaluation, if applicable.*
13. *Patient medical doctor approval (**does not have to be in writing**).*
14. *Family approval (**does not have to be in writing but family MUST approve admit**)*
15. *Copy of resident falls report with dates and injuries.*

Pt Flu Vac Date:_____ Pt Pneumo Vac Date:_____

Does pt have history of MRSA and/or VRE? _____yes _____no. If yes, provide documentation.

Signature of person completing this form: _____

General information:

Items to bring to Hope Harbor: Comfortable clothing for 3 days. Comfortable soft shoe, walker, wheelchair or any assistive devices (please mark with facility name), hearing aids and hearing aid batteries, dentures and glasses. Items NOT to bring: Money, metal hangers, belts, purses/wallets with valuables, valuable jewelry, any glass items or cell phones.

One of the social workers, Zena or Melissa, will call you as soon as information is reviewed and let you know if additional information is needed and when bed available. For questions, please call Zena at 712-213-8671 or Melissa at 712-213-8615. Thank you for your referral!

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Hope Harbor Geriatric Behavioral Health

Phone: 712-213-8656

Fax: 712-213-4034

We have requested inpatient treatment for _____
at Buena Vista Regional Medical Center-Hope Harbor Geriatric Behavioral Health Unit. We agree to have this patient/resident return to our facility when Hope Harbor determines that criteria for discharge has been met.

** We also understand it is the responsibility of our facility to arrange for transportation to and from Hope Harbor.

_____	_____
Facility	Date
_____	_____
Signature of Administrator or DON	Title

Buena Vista
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This form must be completed and returned to Hope Harbor

Patient Name: _____ **Age:**_____ **Facility:** _____

Date of initial referral call: _____

1. **Behaviors & date of each behavior:** Please describe in detail (rather than documenting “aggressive” indicate what the act of aggression was Ex. “Res pulled RN hair”).

2. **Non-medical Interventions Used and Outcome:** What non-medical interventions have been tried and how did the patient/resident respond to these interventions?

3. **Medical Interventions Used and Outcome:** The date the medication was prescribed, by whom and how often. Was the medication beneficial or not?

Completed by: _____ Date/Time: _____