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!

Buena Vista
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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: _____

PLEASE FILL OUT THE FOLLOWING INFORMATION FOR HOPE HARBOR REFERRAL
Return with other referral information

ADMITTING INFO:
Admitting Physician- Dr. _____
History of Covid-19: ☐ No ☐ Yes, Date: _____
Covid Exposure in Last 90 Days: ☐ No ☐ Yes, Date: _____
Covid Symptoms in last 2 weeks: ☐ No ☐ Yes, Symptoms: _____
(If Symptoms or Exposure are marked Yes, Pt will need Covid testing in ER upon admit)
Transportation provided by: ☐Family ☐Facility
PASRR Level Prior to Admission: ☐ Level I ☐ Level II

REFFERAL SOURCE INFORMATION
Caller Name: _____ Organization: _____ Telephone: _____
Facility Address _____ Fax: _____
Level of Care: Skilled / ICF / Assisted Living / Memory Care

PATIENT INFORMATION
Patient Name: _____ DOB: _____ Age: _____ ☐M ☐ F Marital Status: _____
Address: _____ Telephone: _____
County:_____ Ethnicity: _____ Primary Language: _____ Spirituality: _____
Legal Status: ☐ Voluntary ☐ Involuntary Guardianship/Conservator: ☐ Yes ☐ No **POA: ☐ Yes ☐ No**
☐ DNR ☐ FULL CODE Forms sent? ☐ Yes ☐ No

CARETAKER / PHYSICIAN INFORMATION
Responsible Party: _____ Relationship: _____ Telephone: _____
Address: _____ Cell: _____

Primary Physician: _____ Telephone: _____ MD aware of referral? ☐ Y ☐ N
Address: _____

Pharmacy: _____

PRESENTING PROBLEM Briefly describe unusual behaviors reported by patient, family, physician, or referral source:

PREVIOUS PSYCHIATRIC TREATMENT / Long history of psych issues? Yes / No
Previous Psychiatric Treatment: ☐ Site outpatient ☐ Primary care practitioner ☐ Other: _____

Dates and Nature of this treatment Dates: _____ Type: _____

Medication: See Chart
Results: ☒ Pt failed outpatient tx and med adjustment and requires higher level of care in a safe secure environment.

INSURANCE INFORMATION
Medicare:☐Y ☐N Policy # _____
Medicaid:☐Y ☐N Policy # _____
Social Security # (if different from Medicare #) _____
Other Insurance/HMO: _____ Policy # _____

MEDICAL INFORMATION
Diagnosis: _____
Recent Hospitalizations / Procedures: _____
Recent Head CT/MRI: _____
Allergies: ☐ NKA (list) _____

History of: **MRSA:** ☐ Yes ☐ No **VRE:** ☐ Yes ☐ No
Pneumovac ☐ Yes ☐ No If Yes, Date: _____ TYPE_____
Flu Vac ☐ Yes ☐ No If Yes, Date: _____

Covid Vaccine: ☐ No ☐ Yes, Dates: / TYPE _____
Smoker: ☐ Current ☐ Former ☐ Never
Skin Issues: _____
History of Allegations of Abuse:

SOCIALCULTURAL INFORMATION

Current living arrangements: Home / Nursing Home / Assisted Living _____
Date entered assisted living/nursing home: _____
Plans for living arrangements upon discharge: _____
Describe cultural issues or restrictions: _____
Any family history of mental illness, substance abuse, or symptoms similar to patients? _____

CURRENT LEVEL OF FUNCTIONING

Affective
- ☐ Depressed Mood
- ☐ Crying Spells
- ☐ ↓ Interest
- ☐ ▲ Sleep
- ☐ ▲ Appetite
- ☐ ↓Concentration
- ☐ ↓Activity level / fatigue
- ☐ Guilt
- ☐ ↑Activity level / energy
- ☐ Somatic Complaints
- ☐ Mania
- ☐ Suicidal ideation
- ☐ Anger
- ☐ Anxiety / fear
- ☐ Panic attacks

Cognition
- ☐ Disorientation
- ☐ Memory loss
- ☐ Impaired judgment
- ☐ Aphasia
- ☐ Apraxia
- ☐ Agnosia
- ☐ Disorganization
- ☐ Delusions
- ☐ Hallucinations
- ☐ Paranoia
- ☐ Suspiciousness
- ☐ Obsessions

Behavioral
- ☐ Combative
- ☐ Agitation
- ☐ Wandering
- ☐ Bizarre
- ☐ Withdrawn
- ☐ Isolative
- ☐ Compulsive
- ☐ Suicidal

Substance Abuse
- ☐ Alcohol
- ☐ Rx Drugs
- ☐ Non-Rx Drugs

Current Stressors
- ☐ Deaths
- ☐ Illness
- ☐ ▲ living arrangement: _____
- ☐ Marital / family conflict: _____
- ☐ Physical, sexual, emotional abuse: _____
- ☐ Financial:
- ☐ Loss/limited transportation:
- ☐ Other: _____

Onset and duration of problems: _____

ADL ASSESSMENT

√Assist Level:	Independent	Minimal Assist	Moderate Assist	Maximum Assist
Eating				
Bathing				
Dressing				
Hygiene				

Current Mobility _____ Assistive Device: _____ Assist of & Distance: _____

Diet: _____ Appetite: _____ Difficulty swallowing: _____
Refuses to Eat: ☐ Yes ☐ No ☐ Sometimes Refuses to Drink: ☐ Yes ☐ No ☐ Sometimes
☐ Continent ☐ Incontinent of bladder ☐ Incontinent of bowel ☐ Occasionally incontinent ☐ Wears pads/briefs
Fall History: ☐ Past ☐ Present Most recent fall and injury? _____
Medication Compliance: _____ Takes: ☐ Whole ☐ Crushed in: _____
Dentures: _____ Hearing Aide: _____ Glasses: _____
Wt Loss of 10 1bs. or more: _____
Additional information: _____