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!

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

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

And return with other referral information

ADMITTING INFO:

Admitting Physician- ____________________ Transportation provided by:

History of Covid-19: ☐ No ☐ Yes, Date: Admission Covid-19 Test Results: ☐ Negative

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: ____________

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.

MRI / CT Scan??? When and where? ____________

INSURANCE INFORMATION

Medicare:☐Y ☐N Policy # ____________

Medicaid:☐Y ☐N Policy # ____________

Social Security # (if different from Medicare #) ____________

Other Insurance/HMO: ____________ Policy # ____________

MEDICAL INFORMATION

Dx

Recent Hospitalizations / Procedures: ____________

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 ____
Date: 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?? ______________________________
____
________ ______________________________