Hawaii Homeless Healthcare Hui

H4 Punawai Medical Respite
431 Kuwili St.
Honolulu, HI 96817

H4 Medical Respite REFERRAL CHECKLIST

E-mail referrals to: admission@h4hawaii.org. **Admissions are currently done Monday through Friday. We will try our best to notify you in less than 72 hours. There is NO smoking in our facility and we DO NOT offer smoke breaks.**

Patient Name: _____ Patient DOB: _____

☐male ☐female ☐transgender ☐veteran ☐non-veteran

Legal status: ☐ U.S. Citizen ☐ Non-U.S. Citizen

Referring Org/Hospital: _____

Contact Name/Title/Number: _____

Please use this as your REFERRAL CHECKLIST; attach applicable notes and forms required for screening. Mark "N/A" if not applicable.

☐ Homeless? How did you verify homeless status?

☐ Facesheet

☐ History & Physical + most recent progress note

☐ Most recent Behavioral Health note

☐ MAR for the past 48 hours

- patient is off any IV pain medicine for the past 48 hours
- for diabetic patients on insulin, patient to come with glucometer, strips, and lancets.
- if patient requires IV antibiotics, patient must have a PICC Line

☐ Most recent labs and applicable diagnostic reports

☐ Advanced Healthcare Directive, if available

☐ POLST – completed prior to transfer

☐ Vaccination records

For **WOUND CARE** patients:

☐ Most recent Wound Care Consult recommendations / orders

For **long-term IV ANTIBIOTIC** treatment:

☐ most recent ID consult note

For **PT/OT** patients:

☐ Most recent therapy notes

☐ Pls use H4's physician as signing provider for home health referrals – Dr Landis Lum

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For **DIABETIC** patients:

- ☐ Last A1c
- ☐ if on insulin: pt to come with glucometer, strips, and lancets

For **HEMODIALYSIS** patients:

- ☐ HD sessions with dialysis clinic arranged
- ☐ Transportation to/from dialysis clinic arranged
- ☐ Follow-up appointment with nephrology or appropriate provider scheduled

For patients requiring **O2 SUPPLEMENT**:

- ☐ Attach DME form

**** IF accepted, patient must be at H4 by 3:00pm the day of discharge. We also ask that the RN from the referring facility call out H4 RN at (808) 376-5315 to give a verbal handoff report PRIOR to transport. H4 also requests the following documents/supplies listed below; documents can be faxed to (808) 650-5031. Mahalo!**

☐ Discharge Summary

☐ Updated Behavioral Health note

☐ Medication supplies

- patient to come with **30-day** supply of medications (including home medications)
- **3-day** supply for any controlled substance

For **TB CLEARANCE:**

- ☐ Negative PPD reading or negative CXR indicating no active presence of tuberculosis

For **COVID CLEARANCE:**

- ☐ Negative Covid-19 PCR swab within 72 hours prior to discharge OR Covid-19 cleared and negative rapid test the day of discharge if recent (<14 days) Covid-19 infection

For **WOUND CARE** patients:

- ☐ patient to come with **ONE** week supply of dressings
- ☐ updated wound care orders

For **long-term IV ANTIBIOTIC** treatment:

- ☐ PICC line insertion documentation (ex: measurements, verification ok to use)
- ☐ Follow-up appointment scheduled with ID/appropriate provider
- ☐ IV antibiotic orders sent to medical supplier

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H4 Medical Respite REFERRAL FORM

Patient Name: _____ **DOB:** _____

Skilled need: _____

Diagnoses: _____

Behavioral Health / Chemical Dependency Status:

1. Current Mental Status: A/Ox _____
2. Behavioral Health History: _____
3. History of violent behavior? ☐NO ☐YES _____
4. History of suicidal behavior? ☐NO ☐YES _____
5. History of substance abuse / chemical dependency? ☐NO ☐YES
   Substance(s): _____
6. Drug Screen Results? ☐NEG ☐POS for _____
7. Compliant with medication? ☐NO ☐YES
   If no, please explain: _____

Ability to Perform Activities of Daily Living (ADL's) WITHOUT assistance:

1. Walk at least 30 feet? ☐YES ☐NO
2. Does pt transfer independently? ☐YES ☐NO
   Type of ambulatory aide(s): _____
3. Other assistive devices (ex: hearing aid, eye glasses) _____
4. Able to prep simple meals independently? ☐YES ☐NO
5. Feeds self? ☐YES ☐NO
6. Toilet self? ☐YES ☐NO
7. Bathe self? ☐YES ☐NO
8. Maintain good hygiene? ☐YES ☐NO
9. Any communication barrier? (ex: language, hard of hearing) _____
   Primary Language _____
   Secondary Language: _____

Medical Condition:

1. Can self-administer & monitor own meds? ☐YES ☐NO
2. Adherent to all aspects of medical care? ☐YES ☐NO
   If no, please explain: _____
3. Other medical appliances? ☐YES ☐NO (i.e., pacemaker, internal defibrillator, ostomy, prosthetic)
   Does pt manage independently? ☐YES ☐NO
4. Dysphagia diet / stage ☐YES ☐NO _____

Other Comments:

_____

_____

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H4 Medical Respite REFERRAL CHECKLIST & FORM

Patient Name: _____ Patient DOB: _____

Outpatient/Home Health Treatment Services:

Insurance/Member # _____

Service Coordinator: _____ Contact # _____

DME Vendor: _____

Contact person: _____ Contact # _____

Pharmaceutical Vendor: _____

Contact person: _____ Contact # _____

Hemodialysis Clinic: _____

Contact person: _____ Contact # _____

Primary Care Provider: _____ Contact # _____

Community Behavioral Health Provider: _____ Contact # _____