



Haywood Street Respite Referral Form

Directions: Please fill out this form completely and email to Haywood Street Respite at HSRreferral@haywoodstreet.org along with face sheet, history & physical (H&P), recent progress notes (PN) and other pertinent supportive documents. Haywood Street personnel will evaluate the appropriateness of the referral and contact you by email to confirm approval or denial. Patients are accepted five days a week (non-holiday). We ask that all patients be discharged by 2pm to provide time for intake. ****Please note that if the patient is a veteran, they should be referred to ABCCM's Respite Program****

- Discharge instructions must accompany patient to HSR
- Patients must arrive at HSR with at minimum 2 weeks of medications according to discharge instructions

Patient Name _____ DOB ___/___/___ Are they a Veteran (Y/N) _____

Date of Referral _____ Date of Hospital Admission _____ Anticipated D/C date _____

Referring Agency _____ Contact Name _____

Phone Number _____ Email _____ Fax _____

Where did the patient stay the night before entering the hospital _____

Anticipated length of stay at HSR per MD _____

What **acute** medical need are they being referred to respite for _____

Co-Morbidities _____

Please list any medication allergies or OTC drug interactions: _____

Recuperative Care Needs *(Please consider that we are not a Skilled or Rehabilitation Facility)* _____

Does the patient have any communicable diseases or contagious illnesses? _____

Does the patient have a history of behavioral health or substance use disorder? *(please note that neither of these will prevent them from entering respite).* _____

To be completed by HSR Staff

Referral Denied

Date of denial _____ Date denial faxed to referral source _____

Reason for denial _____

Referral Accepted

Anticipated date of admission _____ Date acceptance faxed to referral source _____

Notes _____
