NYC Department of Homeless Services

SHELTER and OUTREACH REFERRAL FORM

PLEASE NOTE:
LEGIBILITY IS THE RESPONSIBILITY OF THE REFERRING FACILITY

☐ **RETURNEE: DHS SHELTER CLIENT WITHIN THE PAST YEAR: HA# _____**
☐ **NEW, PREVIOUSLY-DOMICILED INDIVIDUAL (NOT STREET HOMELESS)**
☐ **STREET HOMELESS INDIVIDUAL BOROUGH:_____**
(Please note that only chronic street homeless patients (those on the streets for a minimum of 9 months over the last 2 years), who refuse shelter placement, can be referred to the borough outreach team. Non-chronic street homeless individuals should be referred to shelter, if an alternative option is not identified.)

☐ **Primary medical inpatient referral** ☐ **Detox**
☐ **Primary psychiatric inpatient referral**

I. HOSPITAL AND PATIENT DATA

A. HOSPITAL/FACILITY INFORMATION

Facility Name: _____ Contact Person: _____

Telephone: (___) _____-_____ x_____ Pager/Cell: (____) _____-_____

Fax: (___) _____-_____ Email: _____

B. PATIENT INFORMATION

Name: _____ DOB: ____/____/____ SS#: ____-___-_____

Alias: _____ Sex: M F Ethnicity: _____

Prior DHS Shelter Resident: ☐ Yes ☐ No If Yes, where? _____ Most recent stay? ___/____/____

Expected Date of Hospital/Facility Discharge: ____/____/____

Citizenship: ☐ US Citizen ☐ Resident Alien ☐ Undocumented US Veteran: ☐ Yes ☐ No

Able to communicate in English? ☐ Yes ☐ No If No, language spoken? _____

Is patient ambulatory? ☐ Yes ☐ No

If No, does patient require a Wheelchair? ☐ Yes ☐ No Cane? ☐ Yes ☐ No Crutches/Walker? ☐ Yes ☐ No

Clinic or Private MD where patient receives care: _____

Phone/pager number of PMD/outpatient clinic: _____

Address of PMD/outpatient clinic _____

Next of Kin: _____ (relationship) Phone: (____) _____-_____

Emergency Contact: _____ (relationship) Phone: (____) _____-_____

PATIENT'S NAME: _____, _____

II. PATIENT'S RELEASE OF INFORMATION AND STATEMENT OF CAPACITY

A. PATIENT'S RELEASE OF INFORMATION:

I, _____(name of patient), give permission to the medical and social work staff at _____(name of hospital), to release the information, below, to the NYC Department of Homeless Services Agency Medical Director's Office, and the Social Services and Medical staff, if any, at my assigned shelter or outreach placement. I understand that this information will be used to help determine if a shelter or outreach placement is an appropriate place for me and, if so, to which shelter or outreach placement I might go. By giving the information to the staff at my assigned shelter or outreach placement, I will be helping them to care for me and to place me into permanent housing more quickly, and avoid having to repeat the blood tests and examinations I have had while I have been in the hospital. I agree to this plan for discharge to a shelter or outreach placement and have rejected, when offered, a more appropriate setting. I understand that I can come into the shelter system without releasing this information. I know that, if I change my mind about releasing this information, I can write or ask someone else to write down this decision and give it to a member of my hospital treatment team. I understand that if the information has already been sent, I cannot ask the hospital to take it back again. I also understand that it is possible that this information will be further disclosed and will no longer be protected. I have a right to a signed copy of this release form. This release is good for three months after my discharge from the hospital.

I permit _____ (name of hospital) to release the following information:

☐ **All information contained or referenced in this Shelter and Outreach Referral Form**

☐ **Information regarding my HIV status**

☐ **Information regarding my use of drugs or alcohol.**

I understand that only the information checked off can be given to DHS.

Patient's Signature: _____ **Date:** ___/___/___

Witness: _____ **Date:** __/___/____

(Include title, as appropriate.)

B. STATEMENT OF PATIENT'S CAPACITY

As the Physician/Nurse Practitioner/Physician's Assistant (circle one) primarily responsible for this patient's inpatient care, I assert that the information contained in this document reflects accurately the patient's condition upon admission and hospital course through discharge, and that, in my clinical judgment, this patient has the capacity to decide to be discharged to a shelter or outreach placement. I have explained fully to this patient that a shelter or outreach placement has limited, if any, on-site medical care, no 24-hour nursing care, and limited medication administration. We have offered him/her more appropriate settings, if warranted by his/her medical condition. He/she has, nonetheless, chosen to go/return to a shelter or outreach placement, and, at this time, has full decision-making capacity to do so.

_____	____/____/____	(___) ____-_____
(Name of Physician/NP/PA)	**(Date)**	**(Pager or phone number)**

PATIENT'S NAME: _____, _____

III. ADMISSION AND HOSPITAL COURSE (to be completed by MD/NP/PA only)

DATE OF ADMISSION TO HOSPITAL/FACILITY: ___/___/___

A. REASON FOR ADMISSION, BRIEF HPI, and HOSPITAL COURSE:_____

_____

_____

_____

B. ALLERGIES: ☐ **Yes** **If Yes, to what?:** _____ ☐ **No** ☐ **Unknown**

C. TB CLEARANCE: Does patient evidence signs or symptoms of active TB? ☐ **Yes** ☐ **No**

- **TST+/Blood Test for TB: Was TST (PPD) done during this admission?** ☐ **Yes** ☐ **No**

  If Yes, what were the results? **Planted: __/___/___ (date)** **Read: __/___/___ (date)** **_____ mm**

- **If CXR, done __/__/__ (date), consistent with:** ☐ **No disease** ☐ **Old TB** ☐ **Active TB** ☐ **Suspicious for TB**

➢ **If pt has Latent TB Infection (LTBI), NYC DOHMH/CDC protocol mandates that the Provider offer/initiate preventive treatment. Has treatment been initiated?** ☐ **Yes** ☐ **No** **If No, why not?** _____

IV. DISPOSITION PLANNING

A. DIAGNOSES UPON DISCHARGE (include all diagnoses)(to be completed by MD/NP/PA only):

1.	**5.**
2.	**6.**
3.	**7.**
4.	**8.**

B. MEDICATIONS (to be completed by MD/NP/PA only) (attach additional page, as needed):

Medication (generic name if possible)	Dosage	Route	Frequency*	Dispensed #: **	Comments (last Dec.? TDM + date?)
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					

***** **Use QD or BID dosing as possible; include dosing for Methadone maintenance (MMTP).**

****** **Document whether medications will be supplied or prescriptions given.**

PATIENT'S NAME: _____, _____

C. SPECIAL ASSISTANCE NEEDED BY PATIENT UPON DISCHARGE: (to be completed by MD/NP/PA)

- **Does the patient have a wound?** ☐ **Yes** ☐ **No** **If Yes, describe:**_____

  _____

  If Yes, does wound require dressing? ☐ **Yes** ☐ **No**
  If Yes, can the patient change the dressing and perform wound care independently? ☐ **Yes** ☐ **No**

- **Does patient need specific labs or diagnostic procedures/imaging to be repeated while in shelter?** ☐ **Yes** ☐ **No**

  If Yes, document which test and when it should be repeated:_____

D. SPECIAL FOLLOW-UP NEEDED UPON DISCHARGE:

- **Does the patient require any special supplies or nursing care upon discharge?** ☐ **Yes** ☐ **No**

  Item(s)/help provided: ☐**VNS** ☐**dressing changes** ☐**syringes** ☐ **glucometer** ☐**other** _____

- **Will patient require any special equipment upon discharge (i.e., wheelchair, cane, walker, etc.)?** ☐ **Yes** ☐ **No**
  If Yes, elaborate:

E. SPECIAL PSYCH FOLLOW-UP NEEDED UPON DISCHARGE:

- **Has petition for AOT been submitted?** ☐**Yes** ☐**No**
- **Has an order for AOT been issued?** ☐**Yes** ☐**No**

  If Yes, attach copy of original court order and treatment plan, document AOT team (_____)
  and provide name and number of ICM/ACT team.

  _____ (___) ____-_____
  Name ICM/ACT Team **Phone Number**

- **Will patient receive Koskinas follow-up?** ☐**Yes** ☐**No** **(For HHC patients, only)**

  If Yes, provide name and number of Koskinas worker.

  _____ (___) ____-_____
  Name **Phone Number**

  If No, why not? _____