REFERRAL FORM

Phone: 858-326-1100 x103 | Fax: 858-326-2200 | Direct: 619-673-8137

Email: admissions@horizoncsd.org

Person Making Referral: ___________________________ **Phone:** _______________**Facility:** _______________________________________

Patient Name: ____ **DOB:** ____

Managed Care Plan: ____ **ID#:** ____

Managed Care CM/Hospital CM Contact: ______________________________ **Phone:** ____

Reason for Referral: ____

Primary Diagnosis: ____

Special Treatments: (i.e. wound care, PT/OT, IV ABTS, respiratory care, glucose monitoring, non weight bearing)

Medical Records:

- ☐ **Admit H&P**
- ☐ **Medications on Discharge**
- ☐ **MD Progress Notes**
- ☐ **Discharge Orders**
- ☐ **PT/OT notes REQUIRED if client is not independent**
- ☐ **TB status. Last PPD Date/CXR**
- ☐ **Behavioral Diagnosis Information**
- ☐ **Special Equipment (DME) (Oxygen) or Other**
- ☐ **Special Dietary Records**

ADLs and Special Needs

Independent with ADLs? YES ___ NO ___

If no, please indicate assistance needed: ___ Minimal ___ Moderate ___ Maximum

Recent Falls? YES ___ NO ___

Continent? YES ___ NO ___

If incontinent, can change own briefs: YES ___NO ___

Is client ambulatory? YES ___ NO ___

If not ambulatory, independent with mobility YES ___ NO ___

Is client alert and oriented? YES ___NO ___

History of Dementia or Alzheimer's? YES ___ NO ___

History of MRSA or other isolation? YES ___NO ____

History of RECENT substance use? YES ___NO ___

If so, describe: ____

Signs of withdrawal? YES ___NO___

Is client on methadone? YES ____NO ___

If so, enrolled in methadone program? YES ___ NO ___

Program information and phone number: ____

Psychiatric Diagnosis: YES ___ NO ___ DX: ____

Is client receiving psychiatric care: YES ___ NO ___

If so, where: ____