Ellen Rice Rest Home
38 Warner St, Springfield, MA 01108
Michael Joseph, Administrator
Phone:413-733-7162 Email: rocket8266@aol.com
Fax: 413-480-0022
Website: ellenriceresthome.com

REFERRAL FORM

SAFETY IS OUR #1 PRIORITY

Please review our Services and Policies sections on our website to carefully consider your client's needs in our level of care. Higher level of care is available and may be more appropriate for your client's success. We look forward to hearing from you and discussing any concerns. Thank you!

The following Referral form is available to complete online at our website in the Online Referral section. Release of Information form is available to download on our site in the Forms section.

Who is making the referral?

Name _____Title_____ Organization _____

Relationship to the Client _____

Email Address for Referral Source

_____

Phone Number for Referral Source. Include area code

_____-_____-_____

Fax Number for Referral Source. Include area code

_____-_____-_____

Client Name_____ Date of Birth ___/___/_____

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CLIENT DEMOGRAPHICS

Client Race

____Black/ African/ African American/ African Descent ____Asian/South Asian

____ Native American/Alaskan Native ____Native Hawaiian/Pacific Islander

____White ____Mixed Race ____Other (Pleased describe) _____

Client Ethnicity ____Hispanic ____Not Hispanic

Language: Primary_____ Secondary (Please describe fluency)_____

Other_____(Please describe fluency)_____

Cultural considerations religion, religious restrictions, customs, celebrations etc. Please describe:

_____

_____

CLIENT DIET AND ACTIVITY

Diet/Special Diet Needs _____

Allergies_____

Movement/Activity Restrictions _____

_____

CLIENT FINANCIAL RESOURCES

How will your client pay for rest home supervised housing services? ☐Private Funds ☐Benefits ☐Other

Does your client receive benefits from SSA? _____Yes _____No

If yes, which benefits?_____

_____

Please be prepared to submit information details with client files in person, by encrypted Email or Fax.

Does your client receive benefits from DTA? _____Yes _____No

If yes, which benefits?_____

_____

Please be prepared to submit information details with client files in person, by encrypted Email or Fax.

Does your client receive benefits from VA? _____Yes _____No

If yes, which benefits?_____

_____

Please be prepared to submit information details with client files in person, by encrypted Email or Fax.

If your client plans to pay privately for rest home services, please describe:_____

_____

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CLIENT HEALTH INSURANCE AND MEDICAL PROVIDERS

Health Insurance Plan_____

Member ID_____ Group ID_____

If multiple policies, list all _____

_____

If no current plan, is your client eligible for Medicare or MassHealth? _____Yes _____No

Please be prepared to submit copies of all health and medication insurance policy cards with policy names/ID and member/recipient ID numbers with client files in person, by encrypted Email or Fax.

Primary Care Provider Name_____Title_____

Organization_____

Street_____ City_____ State_____ Zip_____

Phone_____-_____-_____ Fax_____-_____-_____

*****Date of last physical exam____/____/_____

****Residents are required to have a yearly physical. Please be prepared to provide a copy of the client's last physical exam, preferred within the last 12 months, with client files in person, by encrypted Email or Fax.***

Medication Provider Name_____Title_____

Organization_____

Street_____ City_____ State_____ Zip_____

Phone_____-_____-_____ Fax_____-_____-_____

Pharmacy Name_____

Street_____City_____State_____Zip_____

Street_____ City_____ State_____ Zip_____

Phone_____-_____-_____ Fax_____-_____-_____

Does your client have a Release of Information for all above contacts? ____Yes ____No

Please be prepared to submit a dated Release of Information with specific authorizations for all of the above contacts with client files in person, by encrypted Email or Fax**.** *Release of Information form is available for download in the Forms section on our website.*

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CLIENT CARE TEAM AND EMERGENCY CONTACTS

Casework, Therapeutic and Clinical Care Team and Activities

Please Provide Name, Title, Organization, Address, Phone, Fax, Email for all involved in casework, therapeutic and clinical care, and organized groups/activities for client.

Name_____Title_____

Organization_____

Street_____ City_____ State_____ Zip_____

Phone_____-_____-_____ Fax_____-_____-_____

Additional Name_____Title_____

Organization_____

Street_____ City_____ State_____ Zip_____

Phone_____-_____-_____ Fax_____-_____-_____

Additional Care/ Activities, etc. Name(s) and Contact Information:

_____

_____

Emergency Contact for Client

Name_____ Relationship to Client_____

Street_____City_____State_____Zip_____

Primary/Preferred Phone #1 _____-_____-_____Cell___ Home___ Work___

Additional/Other Method of Contact (email, phone, address) _____

_____

Emergency Contact #2

Name_____ Relationship to Client_____

Street_____City_____State_____Zip_____

Primary/Preferred Phone #1 _____-_____-_____Cell___ Home___ Work___

Additional/Other Method of Contact (email, phone, address) _____

_____

Does your client have a Release of Information for all above contacts? ____Yes ____No

Please be prepared to submit a dated Release of Information with specific authorizations for all of the above contacts with client files in person, by encrypted Email or Fax***.*** *Release of Information form is available for download in the Forms section on our website.*

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CLIENT CRITERIA FOR REST HOME SERVICES

Diagnosis/es: Does your client have mental health, behavioral, developmental, physical/medical diagnoses requiring Level 4 24/7 supervised housing rest home care?

Please list all relevant diagnoses and status:

_____

_____

_____

Physician's Order:

Does your client have a Physician's Order to Admit to Level 4 Care? _____Yes _____No

A Physician's Order to Admit to Level 4 Care is required.

Please be prepared to submit Physician's Order to Admit to Level 4 Care with client files in person, by encrypted Email or Fax.

Vaccination Status:

Is your client up-to-date on this season's influenza and Covid-19 vaccines _____Yes _____No

Influenza Vaccine Lot #_____ Date___/___/_____ Provider _____

Covid-19 Vaccine Lot #_____ Date___/___/_____ Provider _____

Please be prepared to submit proof of vaccination or declination due to medical or cultural reason by encrypted Email or Fax***.***

Medication:

Does your client take medication vaccines _____Yes _____No

Medication Name _____ for condition _____Dose_____

Medication Name _____ for condition _____Dose_____

Medication Name _____ for condition _____Dose_____

Additional Medication Names, Purpose, Dose, Frequency/Directions_____

_____

_____

_____

Please be prepared to submit proof of vaccination or declination due to medical or cultural reason by encrypted Email or Fax***.***

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Additional History:
Does your client have Does your client have a history of any of the following?*

____Immunocompromised

Please describe (current status, treatment, etc.): _____

_____

____Mobility Issues

Please describe (current status, treatment, etc.): _____

_____

____Insulin Dependance/Diabetes Management

Please describe (current status, treatment, etc.): _____

_____

____Substance abuse/misuse/addiction

Please describe (current status, treatment, etc.): _____

_____

___Harming behaviors toward self or others

Please describe (current status, treatment, etc.): _____

_____

___Legal Issues, including history of eviction, conviction of crime, incarceration, etc.

Please describe (current status, treatment, etc.):
_____

_____

**These conditions are highlighted to consider your client's needs in our level of care. Higher level of care may be indicated to best meet your client's needs for success and safety.*

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Presenting Problem/Reason for Referral_____
_____
_____
_____
_____
_____
_____

Other helpful information:

We may request discharge summary, physician and nurse notes, client intake forms and face sheets to be submitted with client files in person, by encrypted Email or Fax. Other helpful biopsychosocial-spiritual information may include (a.) diagnoses, (b.) problems, (c.) medications, (d.) history of addiction or substance abuse, misuse, self-medication current status and treatment, (e.) history of self-harming and suicidal behavior current status and treatment, (f.) history of violence or abuse towards others current status and treatment, (g.) history of hospitalization, (h.) history of legal issues current status and treatment, (i.) history of incarceration, (j.) housing history, (k.) federal and state benefits, (l.) insurance, Medicare, MassHealth eligibility and enrollment status, (m.) primary family/friend supports, (n) community supports and activities, (m.) clinical supports and clinical care team, (o.) strengths, (p.) needs for improvement/support, etc.

_____
_____
_____
_____
_____
_____
_____
_____
_____

Today's Date ___/___/_____