



MEDICAL RESPITE SERVICES
RALEIGH RESCUE MISSION
314 E. HARGETT ST.
RALEIGH, NC 27601

Raleigh Rescue Mission provides medical respite services for homeless males and females. The individuals require medical respite for physical recuperation following minor surgery or serious illness. Any medical assistance and special transportation must be arranged by the referring provider prior to discharge, and the referring provider must provide us written doctor's orders regarding the guest's stay **prior to arrival of the guest at our facility.** The referral guidelines to access these beds are below and may be requested by doctors, nurses, social workers, or discharge planners from the medical provider.

To make referral:

- 1) **Contact Raleigh Rescue Mission Medical Director, Jane Smith, RN at 919-400-3414 to check for bed availability.**
- 2) **The referral form must be complete, ensuring that you include:**
 - a. Written doctor's orders
 - b. Any additional information that may be helpful
 - c. Completed Release of Information Form signed by guest
 - d. Completed Medical Respite Agreement Form signed by guest
- 3) **All referral forms should be faxed to:**
 - a. RRM (Women & Men): 919-341-5680 (Attn: Jane Smith)
Physical Address: 314 E. Hargett St, Raleigh, NC 27601
- 4) **Please send guest to the facility with a referral packet or doctor's note requesting respite.**
 - a. The referral packet must be approved by us to our accepting the guest at the facility.
 - b. We'll make every effort to make a determination in a timely manner on all completed referral forms received.
 - c. Referrals will be accepted Monday - Friday, 8:30am to 4:00pm.
 - d. For weekend discharges please contact Jane Smith by Friday afternoon to arrange for admission.

MEDICAL RESPITE SERVICES REFERRAL FORM

Name:	Date of Birth:	SS#: MR#:
Referring Agent:	Cell/Pager:	Referring Agency:
Referring Provider:	Cell/Pager:	Office #:

Steps to a Medical Respite referral:

- Mon-Fri:** 1. Contact RRM MR Nurse, 919-400-3414, **BEFORE** completing referral form.
 2. Fax Referral Form + D/C Med Form (inpt) + ADL record (inpt) to Medical Respite Services, 919-341-5680.

1. Current Diagnosis: _____

 Chronic Illnesses: _____
 Prognosis: _____

Medical Provider to Complete all Following Sections

2. Admission Criteria – Check Boxes Below (must meet all criteria)

Homeless	Willing to see Respite RN qd and can comply with medial recommendations	
Acute medical problem that would benefit from short-term Respite care (14 days)	Behaviorally appropriate for group setting (including no Known suicidal or assaultive risks)	
Independent in ADL's including medication administration	No intravascular lines (IV lines)	
Independent in mobility (cane, walker, wheelchair)	Does not require > 6 – week respite stay	
Continent of urine and feces	Does not need SNF placement	
Medically stable	Patient agrees to Respite admission	
Is not in active alcohol/drug withdrawal	Diabetics have supplies	

3. If Diabetic, does he/she need training? Yes No

4. Social Services Referrals:

Check all that apply:

Referred to Triangle Disability Associates _____ (caseworker contact info)

Current benefits client is receiving _____

Current Agencies _____

5. Substance Abuse/Mental Health Services: Open case with Mental Health Agency? Yes No

SA/MH Counselor (Agency contact info) _____

Mental Health Diagnosis _____

Drug/s of choice _____

Prior treatment history _____

6. Number of Days requested: _____ (not to exceed 14) days.

7. Follow up appointments made prior to discharge:

8. Level of Functioning:

Physical: Independent ambulation Ambulates with assistance (Circle type: walker wheelchair crutches)

Speech/Vision/Hearing Impairment (Specify): _____

Skin Impairment (Specify): _____

Activities of Daily Living: _____

Independent with self-care

Assistance required with: _____

Primary Language: English Other (Specify): _____

9. Please list all discharge medications (name, dosage & frequency, to include insulin) or attach copy of discharge orders:

Patient must come with enough medication to cover length of stay while using the Medical Respite Services– this is the referring medical provider’s responsibility.

Client has all discharge medications

Client given enough medications for _____ days, until prescriptions filled

Plan for client to obtain discharge medications: (where, when, how)

Specific Care Needs (check all applicable):

Requires Daily Dressing Changes

Wound care orders clear and precise

Dressing supplies given at discharge

Client instructed and will change dressings

Home Health ordered to assist with dressing changes

Agency: _____ Ph: _____

Requires Oxygen (4 liters or less):

Liter flow: _____ Continuous With sleep/exercise Other

Specify: _____

Medical Company: _____ Ph: _____

Requires Nebulizer:

Instructed on use of machine and medication dosage and times

Has medication and machine for nebulizer at discharge

Medical Company: _____ Ph: _____

Has medication ONLY. Machine has been ordered (see company above)

Requires Diabetic Management:

Received diabetic education, understands how to respond to high or low blood sugars

Has glucometer and understands use of meter

Has glucometer and strips until next clinic appointment

Patient performs monitoring independently

Requires Home Health visits:

Agency: _____ Ph: _____

Requires Physical Therapy:

Physical therapy arranged

Agency: _____ Ph: _____

Requires Occupational Therapy:

Occupational therapy arranged

Agency: _____ Ph: _____

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Requires Medically At Risk in Summer (MARS) Homeless persons who are medically at-risk are eligible to participate in the MARS White Flag Program. Persons who are medically at-risk have been diagnosed with illnesses such as diabetes, significant cardiac and respiratory disease, heart failure, Chronic Obstructive Pulmonary Disease, emphysema, asthma, angina, etc. In order to participate in MARS, a person must be evaluated at Horizon Health Center or through the Medical Respite Program in order to document such illness. If a person has never been seen at Horizon, he or she must take a photo ID and a letter from a shelter or Cornerstone stating that he or she is homeless.

Facility: _____

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Referring Provider's Checklist :

- Referring Provider has read and understands the "Attention Medical Provider" cover letter
- Referring Provider has explained and had the guest sign the "Medical Respite Services Agreement" form
- Referring Provider has explained and had the guest sign the "Release of Information" form
- Referring Provider has (or will) completed doctor's orders and submitted to Medical Respite Social Worker

Signature of Referring Provider: _____

To be completed by receiving Medical Respite Services Staff:									
Date Received: _____	Time Received: _____	Shift _____	Supervisor _____	Processing _____	Referral _____	_____	_____	_____	Initials _____
_____ Approved _____ Denied		If denied, why? _____							
Dorm/Bed # _____	Assigned _____	Day/Time _____	Guest is expected to arrive? _____	Doctor's Orders _____	Received _____				
Information entered _____	Shift Synopsis ? _____	Release of Information Received? _____	Orientation Complete _____	HMIS Complete _____					
Would pt have been sent to another facility in lieu of respite? _____, if yes, which facility _____									

RELEASE OF INFORMATION

**Medical Respite Services
Raleigh Rescue Mission and South Wilmington Street Center**

Guest Name: _____ Date of Birth: _____
First MI Last

I, _____ hereby authorize _____
(Guest Name) (Name/Address of Provider Agency)

to release specified information in my records to (circle one) RALEIGH RESCUE MISSION or SOUTH WILMINGTON STREET CENTER/Wake County Human Services. This data shall include:

- Diagnosis
- Treatment plan
- Medical history
- Diagnostic testing
- Lab results
- Identifying information
- Medications
- Doctor's orders

I understand that this information will be used for coordination of bed rest and medical services, temporary housing, and case management assistance.

Other information: This is a TWO WAY RELEASE FOR EXCHANGE OF INFORMATION BETWEEN THE ABOVE NAMED PARTIES

My right to confidentiality has been explained to me and I understand what information will be released, the need for the information and that State statutes and regulations protect the confidentiality of authorized information. In addition, information related to substance abuse in my records is protected under federal regulations and cannot be disclosed without my written consent unless otherwise provided in the 42 Code of Federal Regulations Part 2. I freely consent to the release on information as stated in this document.

This consent will expire on: _____ (specific date, event or condition, not to exceed more that 365 days from signature). I understand that I may revoke this consent at any time but that it will remain valid to the extent releases based on this consent have already occurred.

Client Signature

Date Signed

Witness

Date Signed

Client Signature Revoking Consent

Date

MEDICAL RESPITE SERVICES AGREEMENT
Raleigh Rescue Mission and South Wilmington Street Center

MEDICAL RESPITE SERVICES are for homeless men and women needing short-term bed rest for physical recuperation following minor surgery or serous illness. Before being admitted, the Medical Respite Social Worker must have received and approved a Medical Respite Request Packet, including this form, a completed "Medical Respite Services Referral Form", and a release to exchange information between the Medical Respite staff and the Medical Provider signed by the client. These forms are available from the Respite Coordinator at 919-828-9014 ext 133 and must be completed and faxed to 919-341-5680 before any guest will be considered for admission.

Guests admitted to the Medical Respite Services are granted a specific length of stay. During your stay you will be required to:

- Attend an on-site orientation the first day of stay;
- Remain Alcohol and Drug Free;
- Continuously remain in the area designated except for meals, documented medical and other necessary appointments;
- Have any medical assistance and / or transportation arranged by referring practice and documentation provided to the Nurse;
- Please try to limit your personal belongings (Maximum 4 closed bags);
- Comply with all Medical Respite Services Rules and Expectations, provided upon the day of admission; &
- Attend Chapel services (if your physical & medical health permits it).

During your stay, you will also have an opportunity to complete a checklist for entrance into the Transitional Program, if space is available.

My Signature on this document indicates that I understand and agree to follow these guidelines while receiving Medical Respite Services. I understand I will be provided an orientation on rules and expectations on the first day of my stay.

Printed Client Name: _____

Client Signature: _____ Date: _____

Witness Signature: _____ Date: _____