



MEDICAL RESPITE SERVICES

RALEIGH RESCUE MISSION
314 E. HARGETT ST.
RALEIGH, NC 27601

Raleigh Rescue Mission provides medical respite services for homeless men and women. 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 Sharon Wilkinson, RN at 919-828-9014 x 112 to check for bed availability; if no answer, Contact Pennie Arnold, RN at 919-828-9014 x 136**

2) **The referral form must be complete, ensuring that you include:**

- a. Written doctor's orders
- b. History, physical and any consults
- c. Completed Release of Information Form signed by guest
- d. Completed Medical Respite Agreement Form signed by guest

3) **Fax referral form to:**

Raleigh Rescue Mission Medical Respite Service: (919) 341-5680

4) **Please do not send guest to the facility with a referral packet or doctor's note requesting respite.**

- a. The referral packet must be approved by us prior 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. **Weekend admissions will be on a case by case basis.**

MEDICAL RESPITE 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 medical respite nurse, 919-828-9014 x 112 or 919-400-3414 **BEFORE** completing referral form
 2. Fax Referral Form + History/Physical and consults to Community Medical Respite Program 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 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) Not a registered sex offender	
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:

Referred to Triangle Disability Associates Yes No

If yes, 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:

Medication	Dosage	Frequency

PATIENT MUST COME WITH ENOUGH MEDICATION TO COVER LENGTH OF STAY WHILE USING 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:(_____)_____

.....

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: _____

.....

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 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 Staff:

Date Received: ____/____/____ Time Received: _____am/pm

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 _____ CHINS Complete _____

Would patient have been sent to another facility in lieu of respite? Yes No

If yes, which facility _____

RELEASE OF INFORMATION

**Medical Respite Services
Raleigh Rescue Mission**

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) the SOUTH WILMINGTON STREET CENTER/Wake County Human Services or THE RALEIGH RESCUE MISSION. 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 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 serious illness. Before being admitted, the Medical Respite Nurse must have received and approved a Medical Respite Referral Packet, including this form, a completed "Medical Respite 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 at www.raleighrescue.org and must be completed and faxed to 919-341-5680 before any guest will be considered for admission.

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

- Attend an on-site orientation the first day of stay;
- Remain Alcohol and Drug Free;
- For the first 5 days remain in the area designated except for meals, documented medical and other necessary appointments;
- Have any medical assistance and /or transportation arranged by referring provider 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 on Monday and Friday nights (if your physical & medical health permits it).

2.) 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.

Print Guest Name: _____

Guest Signature: _____ Date: _____

Witness Signature : _____ Date : _____