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Relax,Rest, Recover
GWS

Recuperative Care Referral Form

Referral Source Information

Referring Agency/Facility: _____

Referring Contact Name: _____

Phone Number: _____

Email Address: _____

Date of Referral: ____ / ____ / _____

Patient Information

Full Name: _____

Date of Birth: ____ / ____ / _____

Gender: [ ] Male [ ] Female [ ] Other

Phone Number: _____

Emergency Contact Name: _____

Emergency Contact Phone: _____

Primary Language: [ ] English [ ] Spanish [ ] Other: _____

Insurance Provider: _____

Insurance ID #: _____

Medical Information

Primary Diagnosis: _____

Other Medical Conditions: _____

Medications: _____

Allergies: _____

Special Medical Needs: [ ] Wound Care [ ] IV Therapy [ ] Oxygen [ ] Other: _____

Mobility Status: [ ] Independent [ ] Requires Assistance [ ] Wheelchair-bound

Behavioral Health Concerns: [ ] Yes [ ] No (If yes, please explain: _____)

Hospitalization Information (if applicable)

Hospital Name: _____

Date of Admission: ____ / ____ / _____

Expected Discharge Date: ____ / ____ / _____

Reason for Admission: _____

Attending Physician: _____

Physician Contact: _____

Housing & Social Information

Current Living Situation: [ ] Homeless [ ] Shelter [ ] Street [ ] Other: _____

History of Homelessness: [ ] Yes [ ] No

History of Substance Use: [ ] Yes [ ] No

Currently Enrolled in Social Services: [ ] Yes [ ] No (If yes, specify: _____)

Referral Criteria Confirmation

[ ] The patient requires short-term medical respite but does not need 24-hour nursing care.

[ ] The patient can perform activities of daily living with minimal assistance.

[ ] The patient does not pose a risk of harm to self or others.

Additional Notes or Special Considerations

_____

Referring Provider Signature: _____

Date: ____ / ____ / _____