

HCHN Respite Program Admission/Discharge Form

Name				Date of Birth			
HCHN ID							
		Last	First	Month	Day	Year	

Admission Date: _____

_____ ER/ED visits (past month)

Discharge Date: _____

_____ days hospitalized (past month)

Service Site: Angeline's WBC

Referral Source

- ER/ED-HMC
- ER/ED-Swedish
- ER/ED-Other
- HMC Inpatient
- Swedish Inpatient
- HCH Shelter RN
- HMC Clinic
- HCH Clinic
- Other Clinic (non-HCH)
- Jail/Prison
- Other (specify): _____

Where SLEPT PRIOR to ADMISSION (please be sure that file/chart documentation and client eligibility requirements are met)

- Street/Non-Housing
- Emergency Shelter (includes vouchers)
- Transitional Housing
- Doubled Up
- Motel/Hotel (short-term, self-pay and unstable)
- At Risk (must meet eligibility requirements)
- Unknown

*For the following, you must indicate **where they slept the night prior** to that admission/stay from the choices above (write in blank, do not check off above, and note number of days prior to):

- *Hospital: _____
- *Nursing Home: _____
- *Jail/Prison: _____
- *Treatment Program: _____

Domestic Violence Information

- Check if the patient is currently a victim of domestic violence

- Other (specify): _____

REASON FOR DISCHARGE

- Completed medical treatment
- Non-compliance - Facility policy
- Non-compliance - Respite program policy
- Criminal activity/destruction of property/violence
- Left against medical advice (AMA/AWOL)
- Admitted to hospital (completed appropriate level of respite care)
- Acquired housing before medical treatment complete
- Death
- Needs could not be met (explain): _____

- Other (specify): _____

DISCHARGED from Respite Care To:

- Street/Non-Housing
- Emergency Shelter
- Emergency Shelter [E-Bunk and long-term beds]
- Transitional Housing for homeless person
- Transitional Housing--with family/friends
- Permanent Housing--no subsidy rental
- Permanent Housing--Public Housing
- Permanent Housing--Section 8
- Permanent Housing--Shelter Plus Care
- Permanent Housing--Other subsidized
- Permanent Housing--with family/friends
- Hospital
- Nursing Home
- Jail/Prison
- Psychiatric Hospital/Treatment
- Inpatient alcohol or other drug treatment facility
- Other (specify): _____
- Unknown

	HCHN Problem Code	✓ if Chronic Condition		HCHN Problem Code	✓ if Chronic Condition
Primary Admitting Dx			NEW diagnoses made DURING respite stay (include both medical and psychiatric)		
Additional known diagnoses of pre-existing conditions AT TIME OF ADMISSION (include both medical and psychiatric)					

Signature of person completing intake information: _____ Provider #: _____

Signature of person completing discharge information: _____ Provider #: _____