COTS Mary Isaak Center (MIC) Referral Form

actions: Please fill out form completely, sign, and FAX to (707) 776-4778 (Note: this is a HIPPA-compliant FAX line in the MIC nurses office). You may also send completed form to Bill Hess, 900 Hopper Street, Petaluma, CA 94952.

If the patient is approved, bed space must still be confirmed by calling 776-4777 at 8 Am. Intakes are done at 2 pm. Patients must arrive with discharge papers, a two-week supply of medication, and follow-up appointments.

Referring Institution Name: _____

Address: _____ City: _____ State: ___

Contact: _____ Phone: _____ Fax: _____

Patient Name: _____ Nickname: _____

Date of Birth: ___/___/_____ Gender: ☐ M ☐ F ☐ Transgender

Primary Language: _____ Previous Living Situation: _____

Marital Status: ☐ Married ☐ Divorced ☐ Widow(er)

Veteran ☐ Yes ☐ No Hospice Client: ☐ Yes ☐ No

Primary Physician: _____

Clinic Name: _____

Address: _____

City: _____ State: _____

Contact: _____

Phone: _____ Fax: _____

CURRENT MEDICATIONS AND DOSES:

CURRENT MEDICAL DIAGNOSES (only include diagnoses made by licensed medical professionals):

Eating/Drinking - Ability to eat/drink food/liquids, including equipment and preferences

- ☐ Independent, no help or oversight needed
- ☐ Requires monitoring, encouragement and/or cueing
- ☐ Requires set up (includes cutting up meat and opening containers)
- ☐ Able to feed self, but requires hands-on assistance to guide or hand food/drink item
- ☐ Able to feed self some foods, but always needs to be fed a meal or part of a meal
- ☐ Must be fed, dependent for all foods/fluids

List special diet: _____

Ambulatory: ☐ Yes ☐ No List any restrictions: _____

Can the person climb into an upper bunk? ☐ Yes ☐ No (NOTE: We cannot guarantee a lower bunk)

Is the person's pain controlled with oral medication? ☐ Yes ☐ No

Any history of abuse of pain medication? ☐ Yes ☐ No

Is the person experiencing detox? ☐ Yes ☐ No For what substance: _____

Is the person appropriate for a communal environment of 100 people? ☐ Yes ☐ No

Does the person have any active disease processes? ☐ Yes ☐ No

If yes, please identify: _____

Does the person have any open wounds/sores? ☐ Yes ☐ No

Is the person a trauma victim? ☐ Yes ☐ No

Is the person receiving chemotherapy and/or radiation therapy? ☐ Yes ☐ No

Any communicable diseases, including but not limited to STD, TB, Meningitis, or MRSA? ☐ Yes ☐ No

Does the person have a history of detox or psychotic episodes? ☐ Yes ☐ No

Any seizures in the past 30 days? ☐ Yes ☐ No

Can the person perform all activities of daily living? ☐ Yes ☐ No

If no, list limitations: _____

I certify that the above information is true and correct.

Name / Title	Date	Phone	Fax