



New Brighton Personal Care Home

701 Penn Ave
New Brighton, PA 15066

Respite Care Referral Form

Referral Source Information

- Facility/Hospital Name: _____
 - Discharge Planner Name: _____
 - Phone: _____
 - Fax: _____
 - Email: _____
 - Date of Referral: _____
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Patient Information

- Full Name: _____
 - Date of Birth: _____
 - Gender: _____
 - Primary Language: _____
 - Current Location (Hospital, SNF, Personal Residence): _____
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Emergency Contact / Responsible Party

- Name: _____
 - Relationship: _____
 - Phone: _____
 - Email: _____
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Medical Information

- Primary Diagnosis: _____
- Secondary Diagnoses: _____
- Allergies: _____
- Current Medications (attach list if needed): Yes No
- Recent Hospitalization Reason: _____

Functional Status

- Mobility:
 - Independent
 - Walker
 - Wheelchair
 - Bedbound
- Transfer Status:
 - Independent
 - Assist x1
 - Assist x2
- ADL Assistance Needed:
 - Bathing
 - Dressing
 - Toileting
 - Eating
 - None

Cognitive Status

- Alert & Oriented
- Mild Confusion
- Dementia Diagnosis
- Behavioral Concerns (describe): _____

Care Needs

- Medication Management
 - Special Diet (specify): _____
 - Fall Risk
 - Oxygen Use
 - Hospice Services
 - Home Health Services
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Insurance / Payment Source

- Private Pay
 - Long-Term Care Insurance
 - Other: _____
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Requested Admission Details

- Anticipated Discharge Date: _____
 - Requested Length of Stay: _____
 - Transportation Needed: Yes No
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Additional Notes / Special Considerations


Required Documents Checklist


(Please include with referral)

- Face Sheet
 - Medication List
 - Discharge Summary / Clinical Notes
 - History and physical
 - Physician Orders (if applicable)
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Submission Information

 Email: _____

 Fax: _____

 Phone: _____

For Internal Use Only

- Date Received: _____
 - Accepted: Yes No
 - Follow-Up Notes: _____
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