Today's Date: _____

REQUEST FOR ADMISSION

RUSSELL M. SCOTT, JR. CONVALESCENT CARE CENTER

5803 Harrisburg, Houston, TX 77011

Telephone: (713) 921-7520, Ext. 216, 203

FAX: (713) 923-8743 EMAIL: hdiaz@opendoorhouston.org

Steps to a RMSCCC referral:

1. FAX **Completed** Referral form + H&P + TB results
2. Contact Social Services regarding the referral: x 216, 203
3. Please call at least 48 business hours in advance of anticipated discharge date

Patient Name: _____ D.O.B.: _____ SS #: _____

In possession of State-issued Identification Card? Yes / No State & ID number? _____

Referring Hospital/Agency: _____ Case Manager/Contact: _____

Telephone #: _____ Ext #: _____ Pager #: _____

FAX#: _____ Email Address: _____

Admission Criteria: - Check Boxes Below

Homeless ☐ Capable of dressing changes & or home health ☐

Actively recovering from recent injury, illness or surgery ☐ Orders in place ☐ Behaviorally Appropriate for group Behaviorally appropriate for group setting, (no known suicidal or assaultive risks) ☐

Independent in mobility ☐ Continent of urine and feces ☐

Medically & psychiatrically stable ☐ Ideally does not require > 180 day stay ☐

Detox completed ☐ Does not need skilled nursing facility placement ☐

Two (2) weeks of medications supplied ☐ Agrees to placement in faith based respite facility ☐

Diagnosis requiring convalescent stay: _____

Length of convalescent period: (projected) _____

Medical/Surgical Diagnoses: (please list all) _____

_____

Surgical/Other procedures done at this hospitalization: (please list all) _____

_____

_____

Do you suspect or are you aware of any psychiatric issues in this patient? _____

_____

Psychiatric Diagnoses: _____ **Receiving psych care/where?** _____

Does the patient currently present any cognitive impairment? (i.e., memory, judgment, or concentration deficits?) Y / N. Please describe:

_____

_____

History of drug/ alcohol abuse within the last 12 months? Alcohol ☐ Other _____

Present Ambulatory Status: Fully Ambulatory ☐ Crutches ☐ Wheel Chair ☐ Walker ☐

Other assistive devices required? Y / N Identify: _____

Activity Restrictions / Limitations: (please circle)

Extremity		Wt. Bearing	
RLE	☐	Full	☐
LLE	☐	WBAT	☐
RUE	☐	TTWB	☐
LUE	☐	NWB	☐

Medications—Please **attach** medication list from patient chart and Fax or Email to Social Services:

Medical Equipment / Supplies Required:

1. _____ 2. _____

3. _____ 4. _____

Follow up required: (Please check all that apply)

Clinic appointment _____ / date _____

OT ☐ PT ☐ MHMRA ☐ Other Referrals needed: _____

Health Insurance / Funding and status: (indicate none, pending, active, unknown)

Gold card _____ Medicare / Medicaid _____

VA Benefits _____ Private: (specify) _____