

Hospice/Provider Referral Form



Application for Admission to Grace House Akron

Complete application online or email to admissions@gracehouseakron.org

Applicants must:

Be enrolled in a hospice program

Do not have access to a caregiver or cannot afford a caregiver Have a

DNR CC order on State of Ohio form

No symptoms of COVID-19 or exposure to COVID-19 within 48 hours of admission Does not have an infectious disease requiring adaptation of the house and/or staff Negative TB screening or chest x-ray

Funeral arrangements made or in progress

Medication and equipment delivery prior to resident arrival

Requires supportive care due to safety needs, weakness, or inability to perform one or more self-care activities and does not have someone available 24 hours a day to assist the individual at home

Will accept residents with:

Colostomy

Foley Catheter

Injections performed by hospice staff

Wounds with simple dressing changes

Urostomy

Denver Drain that hospice staff manages

O2 therapy/CPAP/BIPAP

Will not accept residents with:

Insulin dependent diabetes

Residents that wander

MRSA (respiratory)

Tracheostomy

Complicated wounds/dressings

Wandering tendencies

Blood sugar monitoring

Active TB or COVID-19

Ventilator support

Tube Feedings

Injectable medications

Hospice: _____ Referral Contact: _____

Contact Phone: _____ Contact email: _____

Applicant Information

Name: _____
First Middle Initial Last

Date of Birth: _____ Age: _____ Phone: _____

Street Address: _____

City: _____ State: _____ Zip: _____

SSN: _____

Gender: Male Female Transgender Nonbinary

Ethnicity: Hispanic or Latino White Black Asian

American Indian or Alaska Native Native Hawaiian or Other Pacific Islander

Present Location of resident (Hospital, home, etc.): _____

Payor Source: Medicare Medicaid Medicaid Waiver None

Other: _____

Marital Status: Single Married Widowed Divorced Separated

Medical Information

Primary Diagnosis:

Other Medical History:

History of treatment for hospice diagnosis:

Allergies (food, medication, seasonal):

Are there concerns about medication regimen?

COMMUNITY AGENCIES ACTIVE WITH PATIENT:

Agency Name:

Phone:

SOCIAL SERVICE ASSESSMENT / RESIDENT OR FAMILY: Please comment on each Family relationship/support: _____

Home environment (physical & social): _____

Lives Alone Lives with others (if so, who): _____

Has a Caregiver No Caregiver No able caregiver

Number of people in immediate household: _____

Living situation immediately prior to Grace House Akron:

Shelter Streets Eviction Fleeing DV

Home Nursing Home Family Member/Friend Home Without a home

RELEVANT HISTORY, CURRENT DYNAMICS, CURRENT SITUATION:

Over the past six months have the resident, family, or hospice team noticed a problem with:

- Lice/Scabies: _____
- Bedbugs: _____
- Cockroaches: _____
- Other: _____

Sitter/Restraints-Free minimum of 24 Hours: _____

On oral medications and symptoms controlled for at least 24 hours?: Yes No

Cognitive/Emotional/Coping Status: _____

Additional problem areas: _____

History of Smoking: Yes No Comment: _____

History of alcohol use: Yes No Comment _____

History of drug use: Yes No Comment _____

Psych history: Yes No Comment _____

History of domestic violence: Yes No Comment _____

SW signature: _____ **Date:** _____



PATIENT NAME: _____ **DOB:** _____

NURSING SUMMARY:

Vital Signs:

PPS/KPS:

Prognosis: Days Weeks Months

Oxygen Used/Breathing Treatment: _____ Rate: _____ Method: _____

NUTRITION / HYDRATION:

Height: _____ Diet: _____ Weight: _____
 Feeds Self Assist Feed Total Feed
 Own Teeth Dentures

Nausea Vomiting Dysphagia

Appetite: Poor Bites Full meals

Feeding Tube: Type _____ Date Inserted: _____

SENSORY/ COMFORT:

VISION: Poor Blind Glasses Contacts
HEARING: Good Hard of Hearing Deaf Aid: L R Bilat
SPEECH: Adequate Adequate
Sensory Aids: _____
 Difficult Unable
Language: _____

PAIN: Location: _____ Description: _____

PSYCHOSOCIAL:

Mental: Alert Lethargic Comatose Oriented Disoriented Confused Forgetful Depressed
AFFECT: Cheerful Tearful Calm Hostile Flat Fearful Anxious/agitated Withdrawn

Behavior:

Helpful Cognitive Delay Manipulative Combative
 Thoughtful Aggressive Attention Seeking
 Mistrusting Preoccupied Wanders



Tuberculosis Screening Questionnaire

Name _____ Date of Birth _____

Have you ever had a positive TB skin or blood test? Yes No

Do you have symptoms of TB?
(Cough greater than 3 weeks, unexplained weight loss, fever, night sweats, fatigue) Yes No

Have you ever had temporary or permanent residence of greater than 1 month in a country with a high TB rate?
(Any country other than the United States, Canada, Australia, New Zealand, and those in Northern or Western Europe) Yes No

Do you have current or planned immunosuppression?
(This includes HIV infection, organ transplant recipient, treatment with a TNF-alpha antagonist, chronic steroids [equivalent of prednisone \geq 1 month] or other immunosuppressive medication) Yes No

Close contact with someone who has had infectious TB disease since your last TB test? Yes No

Do you currently or have you previously lived in large group settings?
(Such as homeless shelters, correctional facilities, or substance therapy programs) Yes No

If you answered NO to all of the above questions, you are not in a high-risk group and do not need a TB skin test.

If you answered YES to any above questions, you fall into a high-risk group and should have a TB skin test or other tests for TB.

Signature

Date