The Convalescent Care Program Referral Form

Please call 410-598-6758 to confirm bed availability.

Patient Name: _____ Date of Birth: _____

Social Security Number: _____

Hospital or facility name: _____ MRN (if applicable): _____

Referral contact name: _____ Phone number: _____

If patient was hospitalized in the last 30 days, name of hospital: _____

Please check the following to confirm eligibility:

- ☐ Patient is experiencing homelessness
- ☐ Patient is 18 years old or older
- ☐ Patient is recovering from a post-acute medical issue
- ☐ Patient is independent enough to safely manage ADLs and self-administer medication
- ☐ Patient is stable enough with mental health symptoms to exist in a group living environment without creating risk or disruption
- ☐ Patient does not require oxygen or facility is able to provide appropriate oxygen upon patient's discharge. The Convalescent Care Program can only accommodate concentrators, not tanks.
- ☐ Patient does not require IV medications.
- ☐ Be coming from a Baltimore City or Baltimore County hospital or agency

Fax this cover sheet to 443-703-1117 along with:

- history and physical
- most recent provider progress note
- medication list
- information about limitations to activity (recent PT/OT notes)
- wound care orders if applicable
- list of follow-up appointments

You will receive a call regarding acceptance within 24 hours of your fax being received.

CHPB Community Health Partnership of Baltimore

HEALTH CARE for the HOMELESS

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