

# The Convalescent Care Program Referral Form

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

Client Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Hospital or facility name: \_\_\_\_\_ MRN (if applicable): \_\_\_\_\_

Referral contact name: \_\_\_\_\_ Phone number: \_\_\_\_\_

If client was hospitalized in the last 30 days, name of hospital: \_\_\_\_\_

## Please check the following to confirm eligibility:

- Referral is from a Baltimore City or Baltimore County hospital or agency
- Client is experiencing homelessness
- Client is 18 years old or older
- Client is recovering from a post-acute medical issue or from an uncontrolled chronic condition that needs stabilization
- Client is independent enough to safely manage ADLs and self-administer medication
- Client is stable enough with mental health symptoms to exist in a group living environment without creating risk or disruption
- Client 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.
- Client does not require IV medications.

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

- Any and all follow-up appointments
  - NOTE: To ensure clients get appropriate follow-up care in a timely manner, all hospital follow-up appointments must be scheduled and verified. Appointments must be faxed before client's discharge. If insurance precludes scheduling an appointment with the client's current facility, appointments should be scheduled with a facility that accepts the client's insurance.
- 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 get a call regarding acceptance within 24 hours of your fax being received.

