# Encompass Recuperative Care Referral Form

Please complete form & Fax or Email with supporting documentation to the Admissions Team.
Fax: (714) 640-6917
Email: csreferrals@encompasshousing.org
If any question or concerns require a in depth conversation, you can call the team directly with the number listed below.
Phone: (714) 804-5802

Referring Individual Name: _____ Referring Organization Name: _____

Referrer Phone Number: (_____) _____-_____ Referrer Email Address: _____

First name: _____ Last Name: _____ Date of Birth: _____/_____/_____

Medical Ins. Type: ☐ Medicare ☐ MediCal ☐ Private ☐ Other: _____

Primary Insurance Provider: _____ Medical Ins. Number/ CIN: _____

Identified Gender: ☐ Male ☐ Female ☐ Transgender: ☐ MTF ☐ FTM ☐ Other: _____

Primary Language Spoken: ☐ English ☐ Spanish ☐ Chinese ☐ Arabic ☐ Tagalog ☐ Korean ☐ Other: _____

Height: _____ Weight: _____ Allergies: _____

Date of Admission/Visit: _____/_____/_____ Projected Discharge/Transition Date: _____/_____/_____

Admitting Dx/ Chief Complaint(s): _____

General Medical Dx/Problem(s): _____

Mental Health/Substance Use Dx/Problem(s): _____

**Please Attest that individual:**

Can Self-Represent? ☐ Yes ☐ No
Independent w/mobility and transfers? ☐ Yes ☐ No
Continent of Bowel & Bladder? ☐ Yes ☐ No
Independent w/ADLs? ☐ Yes ☐ No
Self-administer all medication? ☐ Yes ☐ No

Impaired cognition? ☐ Yes ☐ No
Require oxygen? ☐ Yes ☐ No
Requires Isolation? ☐ Yes ☐ No
History of Violence? ☐ Yes ☐ No
Registered Sex Offender? ☐ Yes ☐ No

Assistive Devices needed? ☐ Yes ☐ No If Yes, please check: ☐ Walker ☐ Cane ☐ Crutches ☐ Wheelchair

Home Health assistance required with the following (select all that applies): ☐ N/A
☐ Wound Care ☐ IV Abx ☐ Colostomy/Ileostomy/Catheter Care ☐ PT/OT/ ST ☐ Medication Management & Education
☐ Other: _____

Any Special Accommodations Required:
☐ Has a car/vehicle ☐ Has a Service/ Emotional Support Animal ☐ Other: _____

Recommended/ Authorized length of Stay in Recuperative Care: _____ days

Please attach the following supporting documentation: Items with (*) are required.

☐ Face sheet* ☐ H&P* ☐ Medication List* ☐ PT/OT/ST Evaluations ☐ COVID-19 Test Results*
☐ Lab Results ☐ Social Worker Notes ☐ Psychiatric Notes ☐ Surgical Notes