



Respite Intake Fax Form

To the referring physician:

Harmony House Respite Center is a residential facility offering a safe, clean place of respite for up to 17 homeless men with acute medical care needs: men who are expected to complete their outpatient recovery in 6 months.

Although Harmony House Respite Center is not a licensed medical facility and therefore cannot provide direct medical care, the facility is staffed with medically trained personnel to assist the physician in maintaining contact with the patient. We expect you to remain the primary physician for the resident during his stay at the Respite Center. In order to ensure the most appropriate care for each resident, we ask that you keep us apprised of the resident's medical recovery. The resident will bring a short Clinic Visit form to each appointment for you to complete or you may choose to call a member of our Health Services team and discuss your patient's progress at any time.

To simplify the intake process, we have created this Respite Intake Fax Form; it can be completed and faxed directly to Director of Services, at Harmony House Respite Center at 713-221.6224 or 713.236.0120. He will decide if we are equipped to meet the medical needs of your patient and will contact you with a timely determination.

.....
Patient Name: _____

Birth date: _____ Social Security # _____

Race/Ethnicity: Black Hispanic White American Indian
 Asian/Pacific Islander Other

Preferred language: English Spanish Other

Referring Physician: _____

Hospital / Clinic _____

Office Phone: _____ Pager: _____



Harmony House Respite Center and/or
Harmony Health Recovery Center
DOCUMENTATION OF HOMELESSNESS

Date: _____

Participant: _____

Referral Agency: _____

Telephone: _____ Fax No: _____

Case Manager: _____

Prior Living Situation- Where Participant Slept in the Week Prior to Entering the Program:

Please mark one of the following homeless reasons:

Participant is literally homeless:

- A. _____ Residing in a place not meant for human habitation (Street, Park, Car, Bus Station, and Abandoned Building, etc.)
- B. _____ Residing in an emergency shelter
- C. _____ Residing in transitional or supportive housing (for homeless persons who originally came from the street or shelter)
- D. _____ Resides in one of the above (A, B, or C) but is spending up to 30 days in a hospital or other institution

Participant is otherwise homeless:

- E. _____ Is being evicted from a private dwelling unit within the week
- F. _____ Is being discharged from an institution within the week

Verification of Participant's Literally Homeless or Otherwise Homeless Status: (No subsequent residence has been identified; participant lacks the resources and support network to obtain housing)
This section MUST be completed and signed by case manager or Social Worker.

Type of Verification: _____

By: _____ Title: _____ Agency: _____

Comments: _____

Intake Acceptance: In my opinion, without the assistance of Harmony House Respite Center or Harmony House Recovery Center, the above named participant would have to spend a night in a shelter or in a place not meant for human habitation.

Name: _____
(To be signed by Harmony House Employee)
Title: _____ Date: _____

Participant's Signature: _____
(Must be signed by patient.)
Date for Participant: _____

Highlighted areas MUST be completed.



Medical Diagnosis

(Referrals require a medical diagnosis signed by the attending physician)

A current H & P is needed

Patient Name: _____

Referring Institution: _____

Primary Diagnosis: _____

Secondary Diagnosis: _____

TB Testing

Was patient tested for **TB** within the past 30 days? Yes _____ No _____

Date of test: _____ Result of Test (+/-) _____

Was a chest x-ray performed? Yes _____ No _____

If **Yes**, what were the results? Normal _____ Abnormal _____

If **Abnormal**, what treatment was prescribed? _____

If treatment was not prescribed, state reason: _____

Patient's Next Medical Appointment:

Date: _____ Time: _____ Physician Name: _____

Location: _____ Phone: _____

Special Dietary Needs:

Diabetic _____

Lactose Intolerant _____

Low Cholesterol _____

Liquid _____

Low Salt _____

Other _____

Patient Disabilities (check all applicable):

Hypertension _____

Alcohol Abuse _____

Seizures _____

Drug Abuse _____

HIV or AIDS _____

Other _____

Medications Currently Required

Reason

1. _____

1. _____

2. _____

2. _____

3. _____

3. _____

4. _____

4. _____

5. _____

5. _____

Med Supplies Required

Reason

1. _____

1. _____

2. _____

2. _____

3. _____

3. _____

4. _____

4. _____

5. _____

5. _____

Attending Physician's Signature: _____



Psychiatric Evaluation

Harmony House Respite Center is able to serve adult men who are homeless, and are in need of support to complete short term medical recovery. Harmony House Respite Center Staff is not trained to provide services to those patients discharged from a hospital with severe mental illness. The staff is able, however, to provide support services to individuals who are receiving appropriate treatment for a psychiatric illness and who can participate in the daily activities of communal living.

The following information will assist our intake staff in making a decision as to whether the patient you are referring is appropriate for services at Harmony House Respite Center. Admission to Harmony House Respite Center will not be considered unless all the information requested has been provided:

Please describe the patient's current mental status (i.e. confused, alarm disoriented, tearful, and disoriented, etc ...)

Does the patient have a psychiatric history? Yes _____ No _____

If yes, what is the patient's diagnosis? Axis I _____
Axis II _____

If no, does the patient currently present any of the following evidence?

Cognitive Impairment

(I.e. memory, judgment, concentration)

Yes _____	No _____	Thought Disorder
Yes _____	No _____	Dementia
Yes _____	No _____	Paranoia
Yes _____	No _____	Confusion

If the patient has a psychiatric history, psychiatric services must be established before we can accept this patient. What other services will this patient are involved in? (I.e. Day Program, Individual Therapy, etc ...)

Patient's Next Psychiatric Services:

Date: _____ - Time: _____ Provider Name: _____

Location: _____ - Type of Service _____

Date: _____ - Time: _____ Provider Name: _____

Location: _____ Type of Service _____

Date: _____ - Time: _____ Provider Name: _____

Location: _____ Type of Service _____



AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION



PATIENT INFORMATION (Please Print)

Patient Name	Social Security No.	Date of birth	Phone No.
Address	City	State	Zip Code

I, _____, authorize _____ to disclose and provide photocopies of the health-care information indicated below from my medical record to the following party:

Harmony House Respite Center Phone Number _____

Street Address City State Zip Code

Information To Be Released - Covering the Periods of Health Care

From (date) _____ to (date) _____

Please check type of information to be released:

- Admission Sheet
- Autopsy
- Footprints
- Entire Record
- Itemized Bill
- Complete Billing Record
- History and Physical
- Operative Report
- Laboratory Report
- Entire Record Excluding Nurses Notes
- Lab / Slides
- Block / Specimens
- Discharge Summary
- Pathology Report
- Radiology Report (X-Ray, MRI, Ultrasound, etc.)
- Emergency Room Sheet
- Radiology Film (MRI, chest X-Ray, etc.)
- Psychotherapy Notes (If this box is checked, no other box may be checked)
- Clinic Visit
- Other (specify) _____

Purpose of Request / Disclosure

- Treatment or Consultation
- At the request of the Patient
- Claims payment
- Requested for Government Benefit
- Other (specify) _____

Drug and/or Alcohol Abuse, and/or HIV/AIDS Records Release

I understand if any information requested above contains information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, HIV, AIDS, Hepatitis A, B or C testing, and/or other sensitive information, I agree to its release. Check One: Yes No

Re-Disclosure

I understand the information disclosed by this authorization may be subjected to re-disclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act 1996. This facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

This authorization will expire on the following event or date _____ or 180 days from the date of signature. I understand that this authorization may be revoked by the person giving the authorization by written and dated notice to Harmony House Inc., except to the extent that disclosure of information has been made prior to receipt of the revocation by Harmony House Inc.

Signature of Patient or Personal Representative Who May Request Disclosure

I understand that I do not have to sign this authorization, and my treatment will not be denied if I do not sign this form unless specified above under Purpose of Request. I can inspect or copy the protected health information to be used or disclosed.

Signature of Patient Date Signed _____

Authority to Sign if not patient

Identity of Requestor Verified via: Photo ID Matching Signature Other, specify _____