Contra Costa County Respite Form

CAUTION: Federal and State laws protecting confidential patient information apply to patient information contained in this completed form.

RESPITE CLIENT INFORMATION

LAST NAME	FIRST NAME	M.I.

ALIASES	MRN	DOB

ADMIT DATE	MM/DD/YYYY	Medically Cleared Date	MM/DD/YYYY (if applicable)	Discharge Date	MM/DD/YYYY

ADMIT PURPOSE

REFERRING PRIMARY DIAGNOSIS AT ADMISSION:
(only ONE please)

REFERRING PRIMARY PURPOSE(S) FOR ADMISSION (choose all that apply):

- ❑ Anticoagulation
- ❑ Assisting with Follow-up
- ❑ Awaiting Medical Procedure
- ❑ Chemo/XRT
- ❑ Connect w/ MH services
- ❑ Decompensated Med Illness
- ❑ IV Antibiotics
- ❑ Med Management/Teaching
- ❑ Post trauma/fracture
- ❑ Post operative recovery
- ❑ Pre operative care
- ❑ Reconditioning/Rehab
- ❑ Respiratory Support/Rest
- ❑ Wound Care
- ❑ Dialysis
- ❑ Other (specify):

MEDICAL HX

- ❑ Denies / No History
- ❑ Ambulatory Disability
- ❑ Anemia
- ❑ Assault
- ❑ Asthma
- ❑ Autoimmune Dz
- ❑ CAD
- ❑ Cancer
- ❑ Cardiac Arrhythmia
- ❑ CHF
- ❑ Chronic Pain
- ❑ Cirrhosis
- ❑ Cognitive Disorder
- ❑ COPD
- ❑ Dental Condition
- ❑ Derm Condition
- ❑ Diabetes
- ❑ Endocrine
- ❑ GI Disease
- ❑ GYN Disease
- ❑ Hepatitis B
- ❑ Hepatitis C
- ❑ HIV/AIDS
- ❑ Hyperlipidemia
- ❑ Hypertension
- ❑ Neuro disease
- ❑ Obesity
- ❑ Open wounds, skin and soft tissue infection
- ❑ Ortho Condition
- ❑ Osteomyelitis
- ❑ Pneumonia
- ❑ Post-Op Care
- ❑ Pregnancy/Postpartum
- ❑ Renal Disease
- ❑ Seizure disorder
- ❑ Traumatic Brain Injury
- ❑ Thromboembolic Disease
- ❑ Tuberculosis Infx/Dz
- ❑ Urologic Condition
- ❑ UTI
- ❑ Vision Disability
- ❑ Other: ______________

MENTAL HEALTH HX

- ❑ Denies History
- ❑ Adjustment Disorders
- ❑ Anxiety Disorders
- ❑ Bipolar Disorder
- ❑ Depression
- ❑ Impulse Control Disorders Not Elsewhere Classified
- ❑ Mood Disorders
- ❑ Personality Disorders
- ❑ Schizophrenia and Other Psychotic Disorders
- ❑ Sexual and Gender Identity Disorder
- ❑ Somatoform Disorders
- ❑ Substance Related Diagnoses
- ❑ Other (specify):____________

SUBSTANCE ABUSE HX

- ❑ Denies History
- ❑ Alcohol
- ❑ Barbiturates and other sedatives / hypnotics
- ❑ Benzodiazepines and other tranquilizers
- ❑ Cocaine / Crack Cocaine
- ❑ Ecstasy & other club drugs
- ❑ Hallucinogens / PCP
- ❑ Heroin
- ❑ Inhalants
- ❑ Marijuana / Hashish
- ❑ Methamphetamine and other amphetamines
- ❑ Nicotine
- ❑ Opiate (specify) _________
- ❑ Over-the-counter (specify): __________________________
- ❑ Other (specify) _________

MEDICAL RESPITE LINKAGES

- ❑ PC Provider:______________________________________ ❑ Already Active ❑ Reconnect ❑ New Connect ❑ Offered/Refused
- ❑ Diagnostic Labs:__________________________________ ❑ N/A ❑ New Connect ❑ Offered/Refused
- ❑ Diagnostic Imaging: ❑ N/A ❑ New Connect ❑ Offered/Refused
- ❑ Diagnostic Procedure: ❑ N/A ❑ New Connect ❑ Offered/Refused
- ❑ Vaccination: ❑ N/A ❑ Up to Date ❑ Updated ❑ Offered/Refused
- ❑ PHN: ❑ N/A ❑ Already Active ❑ Reconnect ❑ New Connect ❑ Offered/Refused
- ❑ Pharmacy: ❑ N/A ❑ Already Active ❑ Reconnect ❑ New Connect ❑ Offered/Refused
- ❑ Med Compliance/Education: ❑ N/A ❑ On Meds ❑ Restarted ❑ New Teaching ❑ Offered/Refused
- ❑ MH Tx:____ ❑ N/A ❑ Already Active ❑ Reconnect ❑ New Connect ❑ Offered/Refused
- ❑ SA Counselor Referral:_______________________________ ❑ N/A ❑ Already Active ❑ Reconnect ❑ New Connect ❑ Offered/Refused
- ❑ SA Tx Program Referral:_____________________________ ❑ N/A ❑ Already Active ❑ Reconnect ❑ New Connect ❑ Offered/Refused
- ❑ Specialist: ❑ N/A ❑ Already Active ❑ Reconnect ❑ New Connect ❑ Offered/Refused
- ❑ Specialist: ❑ N/A ❑ Already Active ❑ Reconnect ❑ New Connect ❑ Offered/Refused
- ❑ Other: ❑ N/A ❑ Already Active ❑ Reconnect ❑ New Connect ❑ Offered/Refused
- ❑ Medical Insurance: BHC / CCHP/ Medi-Medi / Medi-Cal / Medicare / VA / Private / Kaiser / None / Other:________________ ❑ Already Active ❑ Applied ❑ Received ❑ Offered/Refused

No. of hospitalizations during stay: _______

If Medically Cleared Date was before Discharge Date, Reason for delayed discharge (Choose one):

- ❑ Pending shelter placement
- ❑ Pending housing plan/placement
- ❑ Pending access to insurance
- ❑ Pending medical linkage
- ❑ Pending dialysis unit transfer
- ❑ Not Applicable – client left before being medically cleared

DISCHARGE TREATMENT PLAN:

☐ ENTERED INTO HMIS: DATE: ____________________BY: ____________________