NYC HEALTH+ HOSPITALS | Community Care

Hospitals and Congregate Providers Isolation Hotel Referral Form, send to ExpeditedRef@nychhc.org

This is a referral for: H+H Hotel SNF

Name:	**Date of Birth:**	**MRN#:**	**Phone#:**
Current Location:			**Language:**
Referrer Name and Phone Number:			
Home / Shelter Address:			
Insurance Information:			
Does client have an Intellectual/Developmental Disability? Yes (If yes, select all that apply):			
Autism Spectrum Disorder; Cerebral Palsy; Epilepsy; Familial Dysautonomia/Riley–Day/HSAN-III; Neurological Impairment; Traumatic Brain Injury; Other:			
Has client received services through the New York State Office for People with Developmental Disabilities (OPWDD)? Yes No			
General Activities of Daily Living (select all that apply):	Able to bathe self; Able to dress and groom Self; Able to feed self; Able to enter tub/shower without assistance; Able to toilet self both bowel and bladder; Able to ambulate independently		
Primary Mode of Locomotion (select all that apply):	1 Person Assist; 2 Person Assist; Ambulatory; Bedbound; Cane; Walker; Hoyler Lift; Wheelchair; Other:		
Medical History (select all that apply):	Arrythmia; Asthma; Cancer; Cerebrovascular Accident; Congestive Heart Failure; COVID-19; Diabetes Mellitus; Hearing Impaired; Hypertension; Myocardial Infarction; Visually Impaired; Other:		
Describe client's behavioral health history:			
Describe client's history of suicide attempt or suicidal / homicidal ideation:			
Describe client's history of assaultive or aggressive behavior:			
Does client have any wounds? If yes, describe:			
COVID-19 test date:	**COVID-19 test result:**		
Provide client's Primary Care Provider's name, phone number and address:			
Is client on hemodialysis? If yes, specify dialysis schedule and location of client's dialysis center:			
Is client on Methadone? If yes, specify the name, address and phone number of client's Methadone Treatment Program:			
Is client taking any medications? If yes, list all of client's medications:			