Medical Respite Referral Form

Patient Information

Date of Referral: _____ Anticipated Discharge Date: _____

Client Name _____ Date of Birth: _____

Referring Organization: _____ Referral Contact Name: _____

Diagnosis: _____

_____

Medical reason that respite is needed: _____

_____

Housing Information: (Select all that apply)

☐ Sleeping in shelter immediately before hospital entry

☐ Sleeping on streets immediately before hospital entry

☐ No housing discharge location available

☐ Not Homeless

1. E-mail completed Screening Form (2 pgs.) and PT/OT/RN/MD notes to MedicalRespite@texashealth.org

   Referrals will be reviewed in the order of receipt

   Turnaround times are 24-48 hours depending on complexity

   Referrals received after 4pm or on holidays will be reviewed the next business day

2. Texas Health Resources staff will reply to referring agency regarding follow-up questions and status.

3. Intakes occur Monday - Friday 9am - 12pm. Client must present to Austin Street center during this time.

4. Referring staff will set up transport and notify Texas Health Medical Respite of final date and approximate time of entry.

5. Referring facility must send a 30-day supply of prescribed medication with the patient along with written discharge instructions.

6. ID/Discharge paperwork will be required on presentation to Austin Street Center

Continue to second page for preliminary screening

Texas Health

Screening Criteria

Inclusion Criteria – The client is NOT ELIGIBLE if any of these answers are "NO"

Can the client provide a copy of their ID or medical record face sheet?	Y ☐	N ☐
Is the client an adult? (Age 18 or over)	Y ☐	N ☐
Does the client weigh less than 375lbs (170.45kg)	Y ☐	N ☐
Is the client able to self-care without nursing assistance?	Y ☐	N ☐
Can the client eat independently?	Y ☐	N ☐
Can the client ambulate with no assistance?	Y ☐	N ☐
Can the client get in and out of bed with no assistance?	Y ☐	N ☐
Can the client bathe and use the restroom without assistance?	Y ☐	N ☐

Exclusion Criteria – The client is NOT ELIGIBLE if any of these answers are "Yes"

Does the client have intensive medical needs?	Y ☐	N ☐
(wound vac, trach suction, vascular lines)		
Is the client currently having suicidial/homicidial ideation?	Y ☐	N ☐
Does the client require dementia or cognitive care?	Y ☐	N ☐
Does the client require medication management for withdrawal?	Y ☐	N ☐
Is the client currently in isolation status for:		
C. Diff	Y ☐	N ☐
MRSA	Y ☐	N ☐
TB	Y ☐	N ☐
Bed Bugs	Y ☐	N ☐
Scabies	Y ☐	N ☐
Does the client require a urinal?	Y ☐	N ☐

Prognostic Criteria – Eligibility determined on case-by-case basis

Does the client require oxygen therapy?	Y ☐	N ☐
Only o2 concentrators can be accepted		
Does the client require suboxone or methadone therapy?	Y ☐	N ☐
Is the client on dialysis?	Y ☐	N ☐
Does the client require hospice or palliative care?	Y ☐	N ☐
Is the client appropriate for a group setting?	Y ☐	N ☐