BOSTON HEALTH CARE FOR THE HOMELESS PROGRAM
McINNIS HEALTH GROUP

Barbara McInnis House Initial Referral Form

Please **fax** referral to the Admissions Department at **857-654-1112 (f)**
Follow-up with a **phone call** and check on status of referral at **857-654-1760 (p)**
After 4pm call 857-654-1840 to check on a referral's status

Patient Name: _____
DOB: _____
Insurance Carrier: _____

Facility/Hospital: _____
Contact Name: _____
Contact Number: _____

Acute Medical Need/Reason for Referral: _____

Code Status: _____

Required Admission Criteria

- ☐ Homeless in city of Boston
- ☐ Has an acute medical condition
- ☐ Independent with all ADLS
- ☐ Independent with mobility
- ☐ Continent of urine and feces
- ☐ Behaviorally appropriate for group setting

Anticipated Patient Needs

- ☐ Wound care
- ☐ Dialysis (*clinic name and location*: _____)
- ☐ Uses assistive device (*type*:_____)
- ☐ Bariatric equipment
- ☐ Methadone maintenance therapy (*fill out confirmation sheet attached*)
- ☐ PICC line/midline for IV antibiotic (*fill out PICC info sheet attached*)
- ☐ Foley/ostomy (*Include equipment information)*
- ☐ Precaution room
  - ☐ Contact (C-diff) ☐ Droplet (influenza)

Please attach the following paperwork required for screening:

- ☐ History and Physical (H&P)
- ☐ Current medication list
- ☐ Provider progress notes (most recent)
- ☐ Nursing progress notes (most recent)
- ☐ Current lab values

If applicable:

Psych & social consults	☐ Attached	☐ Not applicable
PT/OT notes (most recent)	☐ Attached	☐ Not followed by PT/OT
IV information sheet	☐ Attached	☐ Does not require IV antibiotic
Methadone confirmation	☐ Attached	☐ Not on methadone maintenance
MOLST (if DNR/DNI)	☐ Attached	☐ Full code, not applicable

Barbara McInnis House Admissions Department
780 Albany Street, Boston, MA 02118
Tel: 857-654-1760, Fax: 857-654-1112
Evenings/weekends Tel: 857-654-1706, Fax: 857-654-1115

INFORMATION NEEDED ON ALL ADMISSIONS on IV ABX

All IV antibiotics must be infused through a PICC line/ midline

Patient Name: _____ **DOB**: _____/____/_____

Reason for antibiotic: _____

1. Type of central line: ☐ PICC ☐ Midline
2. Length of line (in cms): _____ Size of line: (ie: 4 Fr) _____
3. Date line placed: _____/____/_____
4. Placement confirmed by: ☐ ECG ☐ CXR
5. Number of lumens: _____
6. Name of antibiotic: _____
7. Dose: _____ Frequency: _____ Time: _____
8. Antibiotic end date: ___/____/____
9. Date IV dressing last changed: _____/____/_____

If on vancomycin:

Vancomycin trough # _____ Date: _____/____/_____

Next trough due: _____/____/_____

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METHADONE CONFIRMATION SHEET

Please Note: Before a patient receiving Methadone for opioid addiction can be accepted to the Barbara McInnis House, the referring agency must complete the form below which demonstrates that they have confirmed that the patient can receive daily dosing at a Methadone Clinic in the Boston area.

Patient Name: _____

Date of Birth: _____

Methadone Clinic Site & Address:

_____

_____

_____

Clinic Contact Person: _____

Clinic Telephone Number: _____

Current Methadone Dose: _____

By signing below, I attest that I confirmed the information on this sheet with the methadone clinic noted above.

Print name: _____

Signature: _____

Date: _____/_____/_____