Barbara McInnis House Initial Referral Form

Please fill form out completely. Include additional forms if prompted. Fax to Admissions Department. Follow up with a phone call.

Admissions Department: Mon-Fri 8am-4:30pm  
Fax: 857-654-1112  
Phone: 857-654-1760

Nursing Supervisor: (weekend or evening admissions only) 
Fax: 857-654-1115  
Phone: 857-654-1840

Date: __________ 
Referring Facility: ___________________ Contact: ___________________

Phone#: ___________________

Medical Reason for Referral: ________________________________

Barbara McInnis House Required Admission Criteria

☐ Homeless  ☐ Continent of urine and feces
☐ Has an acute medical condition  ☐ Behaviorally appropriate for group setting
☐ Independent with all ADLs (including no recent attempts of suicide or violence)
☐ Independent with mobility
☐ Check here if one or more of these criteria are NOT met at this time but are expected to change prior to discharge.

Withdrawal Information

☐ Required meds for detox while inpatient and detox is completed.
☐ Currently detoxing ➤ Drug of choice: ___________________

Anticipated Patient Needs (Please check appropriate boxes and include details within referral paperwork)

☐ Uses oxygen  ☐ Wound care
☐ Dialysis  ☐ Special diet: ___________________
☐ Uses assistive device  ☐ Tube Feeds
☐ Bariatric equipment will be needed  ☐ Foley OR ostomy (Include equipment info)
☐ Once daily methadone for maintenance  ☐ PICC line (Complete IV Antibiotics Information sheet)

☐ Other: (please specify) ___________________

Legal Considerations

☐ Medical Orders for Life Sustaining Treatment (MOLST)  
☐ Ankle bracelet in place  ☐ On parole
☐ Recently incarcerated (List parole officer’s name and contact information: ____________________________________________)

TB Status

☐ I have read and understand the BMH TB policy
☐ Date of most recent PPD/CXR: ___________________  ☐ Results: ___________________

☐ I Confirm that I have also attached all paperwork required for screening:

☐ Current Med List  ☐ IV info sheet and CXR or ☐ Not Applicable
☐ D/C Summary or Encounter Description  ☐ Methadone Confirmation or ☐ Not Applicable
☐ Pages 1, 2, 3 & 4  ☐ Pertinent Psych and Social Consults
☐ Pertinent Labs and Studies  ☐ Follow up Appointments
☐ PT Clearance

Thank you for your referral. Please follow up by calling the Admissions Department. 857-654-1760
Barbara McInnis House Initial Referral Information

TB SCREENING POLICY

All homeless persons are at high risk for TB.

Any homeless person with a new cough or change in cough for three weeks or with pulmonary symptoms suggestive of pneumonia must have a Chest X-ray.

Any infiltrate, regardless of lobe or lobes, or any unexplained pleural effusion should be viewed as suspicious for TB. Consequently, any homeless person with the aforementioned respiratory symptoms and any sign of an infiltrate on CXR should be considered suspicious for TB until proven otherwise.

These patients will not be admitted to the McInnis House until three AFB smears are negative, or the CXR shows definite signs of clearing on an antibiotic regimen, or the patient demonstrates clear clinical improvement (resolution of fever for at least 24 hours or absence of a productive cough) after 72 hours on antibiotics.

High-risk patients for whom AFBs has not been sent will need to be cleared by the Medical Director of the McInnis House prior to admission.

Persons with AIDS are at greater risk for TB, and often the CXR can be negative.

Consequently, any homeless patient with AIDS with a productive cough is required to have three negative AFB smears REGARDLESS OF CXR FINDINGS.

These patients must be cleared by the Medical Director of the McInnis House prior to admission.

PUBLIC HEALTH/COMMUNICABLE DISEASE DISCLOSURE

We have been witness to a rise in the incidence of numerous communicable diseases over the past few years. In order for our staff to properly care for patients and manage their illnesses effectively we require disclosure of known communicable disease. This is especially true, but not limited to patients who have a history of TB, VRE, and MRSA. We will evaluate each case on an individual basis.
INFORMATION NEEDED ON ALL ADMISSIONS on IV ABX
All IV antibiotics must be infused through a PICC line/ midline

Patient Name: _______________________________ DOB: _____/_____/_____

Height: ______  Weight: ______  Allergies: _______________________________________

Diagnosis for Antibiotics: _______________________________________________________

Any Conditions?:   CHF ☐  Diabetes ☐  Kidney Disease ☐  HTN ☐

1. Type of Central Line: _______________________________________________________

2. Length of Line (in cms): ___________  Size of Line: (ie: 4 French) ___________

3. When was the Line Placed: ___________

4. Chest X-Ray done after Placement: ☐ YES  ☐ NO

   Send CXR placement confirmation: ☐ Completed

   Send PICC line placement confirmation: ☐ Completed

5. How many Lumens: _______________

6. Lumens Patient: ☐ YES  ☐ NO

8. Lumens Labeled: ☐ YES  ☐ NO

9. Name of Antibiotics: _______________________________

   Dose: ___________  Frequency and Time: ___________  Stop Date: ____/____/_____

10. IV Dressing last changed: Date: ____/____/_____

11. Trough # _____  Date: ____/____/_____

   Next Trough Due: ____/____/_____  CREAT: _______________

12. BUN: _______________

METHADONE CONFIRMATION SHEET

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:
________________________________________________________
________________________________________________________
________________________________________________________

Telephone Number: ________________________________________

Contact Person: ____________________________________________

Dosing Time: _____________________________________________

Signature: _________________________________________________

Date: ______/_____/__________