BOSTON HEALTH CARE FOR THE HOMELESS PROGRAM
McINNIS HEALTH GROUP

Patient Name:
DOB:
Gender: M F MtF FtM Other:
Insurance Carrier:

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
- ☐ Has an acute medical condition
- ☐ Independent with all ADLS
- ☐ Independent with mobility
- ☐ Continent of urine and feces
- ☐ Behaviorally appropriate for group setting (including no recent attempts of suicide or violence)
- ☐ **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
- ☐ Dialysis
- ☐ Uses assistive device
- ☐ Bariatric equipment will be needed
- ☐ Once daily methadone for maintenance (Complete Methadone Confirmation Form)
- ☐ **Other:** (please specify) _____
- ☐ Wound care
- ☐ Special diet: _____
- ☐ Tube Feeds
- ☐ Foley OR ostomy (Include equipment info)
- ☐ PICC line (Complete IV Antibiotics Information sheet)

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

Thank you for your referral. Please follow up by calling the Admissions Department. 857-654-1760

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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.

Barbara McInnis House
780 Albany Street, Boston, MA 02118
Tel: 857-654-1760
Fax: 857-654-1112

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: ____/____/_____
12. BUN: _____ CREAT: _____
13. On Day of Discharge: Timing of last dose: _____

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

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: _____/_____/_____