Email to HooperReferrals@ccconcern.org

CENTRAL CITY CONCERN
HOMES HEALTH JOBS

HOOPER DETOXIFICATION CENTER REFERRAL FORM

Today's date:	*Please email referrals prior to 3pm for next morning triage consideration. Patient must have discharge plan and agency contact in place prior to admission in order to qualify for referral program.*

PATIENT INFORMATION

Patient's name:	DOB:	
Primary Detox protocol: ☐ ETOH ☐ Opiate ☐ Opiate/ETOH ☐ CNS ☐ Other _____	Amount per day:	Date of last use:

Does the patient have chronic medical condition(s)?	☐ Y ☐ N	Chronic Medical Conditions:
Does the patient require oxygen therapy or IV?	☐ Y ☐ N	
Can the patient perform his/her own ADLs?	☐ Y ☐ N	
Is the patient currently taking medications? (10 day supply required)	☐ Y ☐ N	Patient Medications:
Is the patient prescribed Coumadin? ☐ Y ☐ N What was the date and value of the most recent INR? _____ _____		

INPATIENT OR EMERGENCY DEPARTMENT REFERRAL

Discharge diagnosis:			
Studies performed?	☐ Y	☐ N	Results:
Studies or labs pending?	☐ Y	☐ N	
Follow-up?			

REFERRING AGENCY INFORMATION

Attach Release of Information (ROI) for notification of patient admission status.

Referred from: ☐ Health Share ☐ Family Care ☐ Community Partner ☐ Other _____	
INTAKE:	
Name of referring Agency:	
Name of contact person making referral:	Phone #:
DISCHARGE:	
Name of Agency patient is to be discharged to:	
Name of contact person for discharge planning:	Phone #:
Notes for processing:	