Referral Form

Solace House of the Ozarks, Inc.

Criteria for Admission to Solace House of the Ozarks

- Each guest must be contracted with a local, Medicare-certified hospice provider.
- Each guest must have a terminal diagnosis and prognosis of approximately 30 days or less.
- Guests will be admitted for end-of-life care on a first-come, first-served basis as long as their needs are with our scope of care.
- Each guest will have a DO NOT RESUSCITATE (DNR) order in place.
- Guests with Stage III or IV pressure ulcers or contagious infections **will not** be admitted.
- Guests **may not have** behavioral issues that may cause a danger to themselves or others
- Guests **will not** be admitted if skilled nursing care is required. This includes: trach care; IV medication administration – either through IV push or portable medication pumps; nutrition through feeding (gastronomy or nasogastric) tubes; extensive wound care; blood sugar checks; drains of any kind; ileostomy or colostomy needs. ***These items fall outside our scope of care.***
- Guests **must** come from the hospital with foley already inserted. Emptying foley catheter bags for urine **is** however within our scope of care.

Today's Date

Patient Name____Date of Birth__________________

Home Address ____
House Number & Street City State

Next of Kin, DPOA Name ____

Family Contact Phone ____

Referral Source____

Hospice Provider (Company Name, Primary Case Mgr., Phone Number)	
Primary Care Physician or Treating Physician, Name and Phone Number.	***This is vital information as our consulting physician needs to be able to confer with the physician(s) directly involved in the patient's current care.***

Patient Medical Information

Diagnosis (Hospice dx and/or contributing factors) and complications. Please describe.

Does the patient have a prognosis of approximately 30 days or less? _____Yes _____No

Is the patient currently eating and/or drinking? _____Yes _____No Please list details.

____

Is the patient ambulatory or bed bound? ____

Does the patient require more than a one-person assist for transfer/movement? ___Yes ___No

If yes, please explain. ____

Does the patient have any current infections? (If yes, list details.) _____Yes _____No

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Does the patient have any wounds? (If yes, list details.) _____Yes _____No

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Does the patient have an NG tube/PEG tube or other artificial nutrition? _____Yes _____No

Please provide information regarding the patient's need for Solace House (living situation, family caregiver, etc.)

By submitting this form, you are giving Solace House of the Ozarks, Inc. permission to seek information from providers to confirm the details provided above.

*Please be advised that referrals are processed as quickly and efficiently as possible, but the **referral process** can take anywhere from **24 -72 hours**, therefore, it is of utmost importance that you provide as much information as possible and that you provide all the necessary phone numbers for those who are currently and directly involved in the patient's care.*

Submitting a referral form does not guarantee admission to Solace House.

Please email this form to:

referrals@solacehouseoftheozarks.com

Please call 417-726-5139 or 417-208-9292 with questions.