Health Care for the Homeless

Endeavors Respite Program referral form

Patient name: _____ Patient number (hospital/cell): _____

Date of birth: _____ Referral source: _____

Referral contact (name/number) : _____ Expected discharge date: _____

Please email most recent therapy notes and H&P along with this form.

Patient must be independent in all ADLs (dressing, eating, toileting, showering, transferring and ambulating 100 feet).

Is the patient independent, or will they be completely independent in ADLs at time of referral?

Yes ☐ No ☐

Is this patient experiencing literal homelessness (staying in a shelter, on the streets, or couch hopping?

Yes ☐ No ☐

Is the patient interested in participating in a short-stay respite program?

Yes ☐ No ☐

Does patient have a case manager or other social services support? If yes, provide name and contact.

Yes ☐ No ☐ _____

Does the patient have medications for the next 30 days?

Yes ☐ No ☐

Does the patient have all home equipment they will need in the next 30 days?

Yes ☐ No ☐

Does the patient have any special diet needs? If yes, specify (e.g., soft diet, pureed) and length of time.

Yes ☐ No ☐ _____

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