



Process for Discharging Homeless Patients From Inpatient Medical Facilities to DHS Shelters

Effective July 1, 2010



Overview of Training

- 1) Why change and process overview
- 2) Brief overview of services for street homeless individuals
- 3) Step-by-step review of process
 - a. Treatment Team roles
 - b. Shelter/Safe Haven Director/Outreach team roles
 - c. Specifics of process
 - d. Review of forms
- 4) Case studies – inappropriate vs. appropriate discharges
- 5) Open up for questions

Why Change?

- Effective July 1, 2010 there will no longer be an MRT contract or a PRU unit at DHS.
- DHS will now be allowing inpatient medical facilities to discharge appropriate patients directly to the DHS shelter system with no lengthy approval process.
- DHS has also set up a process for appropriate clients to be referred to Safe Haven and Outreach Programs.
- Based on a decades of experience, we have revised and streamlined the hospital discharge forms to make the process quick and easy.



Services for Street Homeless Individuals

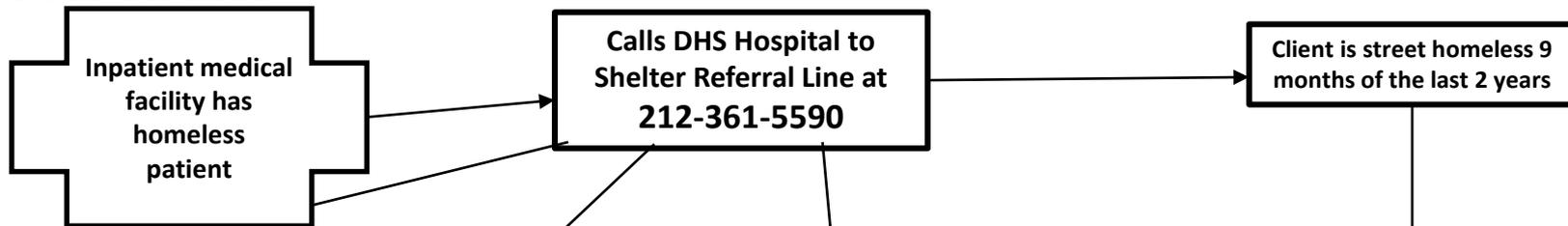
- In September 2007, we re-procured the outreach portfolio, pooling the resources of DHS and DOHMH, and specified clear catchment areas and single, responsible contractors for each area.
- We implemented four new contracts with aggressive, measurable performance targets.
- Teams are funded to provide general outreach services and to focus case management and housing placement resources on most chronic and vulnerable individuals. We define chronic homelessness as spending 9 months of the last 2 years on the streets, in parks, or on the subway.
- DHS developed lower threshold transitional housing options, such as safe havens and stabilization beds, based on feedback from individuals sleeping on the streets.

Overview of process

- First, inpatient medical facilities are expected to make every attempt to discharge a patient to a non-shelter setting and prevent a patient from entering or re-entering the shelter system.
- If a homeless individual's discharge to shelter cannot be prevented, inpatient medical facilities will communicate directly with shelter/safe haven staff/outreach teams regarding appropriate discharges of their shared patients/clients.



REFERRAL AND DISCHARGE OF HOMELESS INDIVIDUALS TO DHS



Patient was in shelter within past year and is willing to return:

Inpatient medical facility begins process to discharge patient directly to patient's official shelter, and follows below process, sending forms directly to appropriate shelter

Patient was not in shelter in past year OR has never been in DHS shelter but is willing to go:

Inpatient medical facility begins process to discharge patient to the appropriate Intake site and follows below process, sending the forms directly to the Intake site

Patient was in Safe Haven within past year and is willing to return:

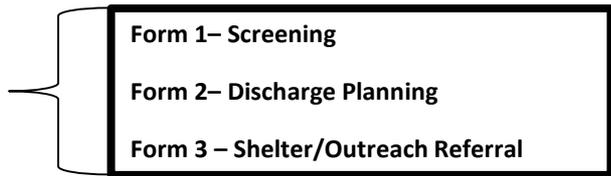
Inpatient medical facility reaches out to see if the Safe Haven has a bed and if patient can be accommodated. If they do not, inpatient facility offers shelter and /or contacts outreach

Patient reports or is known to be chronically street homeless and is unwilling to enter shelter:

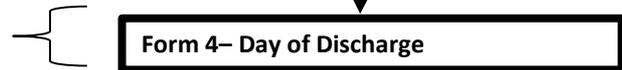
Inpatient medical facility contacts borough outreach team and works with team to determine appropriate actions. If d/c to outreach, Inpatient medical facility follows below process, sending forms directly to outreach

SHELTER AND OUTREACH REFERRAL FORM SUBMISSION PROCESS

Forms are faxed at least 24 Hours before patient discharged from inpatient medical facility



Faxed the day the patient is discharged from the inpatient medical facility



Submitted to the DHS Office of the Agency Medical Director, if requested





During Inpatient Stay (Shelter/Safe Haven)

- Inpatient Medical Facility will contact Hospital to Shelter Referral Line (**212-361-5590**) to determine shelter/safe haven history of a patient and obtain official shelter/safe haven contact numbers.
- If patient has official shelter/safe haven that s/he stayed in the past year, inpatient medical facility will forward a completed referral to that shelter/safe haven.
 - If patient can not be accommodated at the safe haven, inpatient medical facility should encourage them to go to Intake. If they refuse, the medical facility should refer to the borough Outreach Team.
 - Exceptions may be made for street homeless patients, who may have had a shelter stay, but, are unwilling to return, and meet the definition of chronic street homelessness. These should be routed through Outreach.
- If patient is **new or has been out of shelter for more than one year**, the inpatient medical facility should fax a completed referral to the appropriate intake center:
 - For Men: Intake at 30th Street (wheelchair accessible) - fax # **917-637-7372** (DHS Office of Medical Director)
 - For Women: HELP Women's Center in Brooklyn - fax # **718-240-9178** / phone # **718-483-7700**
 - For Women: Franklin Shelter in the Bronx (wheelchair accessible) - fax # **929-281-2312** / phone # **929-281-2330**



During Inpatient Stay (Street Homeless)

- A client must meet the following 3 conditions in order for the inpatient medical facility to contact Outreach:
 - Is chronic street homeless (spent at least 9 months of the last 2 years on the streets)
 - Client is unwilling to go to shelter
 - Hospital has not identified an alternative placement
- Medical facility will contact appropriate borough Outreach Team to collaborate on a discharge plan.
- If client is known to Outreach and meets eligibility for caseload, the team will attempt to place the client directly from the medical facility.
- If client is unknown to Outreach, the team will be expected to visit and engage the client within 24 hours of the medical facility reaching out.

24 Hours Pre-Discharge

- For patients/clients being referred to Intake, Shelter, Safe Haven or Outreach, Inpatient Medical Facility faxes Forms 1, 2, and 3 to the appropriate contact.
 - 1) *Form 1* – DHS Screening Form For Shelter and Outreach Referral
 - 2) *Form 2* – DHS Discharge Planning Worksheet
 - 3) *Form 3* – DHS Shelter and Outreach Referral Form

Day of Discharge

- *Form 4* – Inpatient medical facility sends DHS Day of Discharge Form – to shelter, safe haven or outreach



Shelter/Safe Haven Director Role: Reviewing Forms

- Shelter/Safe Haven Directors or Directors of Social Services will closely monitor and review incoming forms.
- If client cannot be accommodated in official shelter, Shelter Director will contact Inpatient Medical Facility , directly, with an alternative shelter to which to send patient.
- If patient can not be accommodated at the Safe Haven, the Director will contact Inpatient Medical Facility, directly, with suggestion to refer to shelter/Intake or contact borough Outreach Team.
- If there is need for clarification, shelter/safe haven staff will contact inpatient medical facility directly.



Shelter/Safe Haven Director Role: Bed Placement

- Next bed at shelter is prioritized for incoming client.
- If no bed is/will be available, the Shelter Director should notify Program Administrator. Shelter Director will notify inpatient medical facility of alternative placement.
- If the client arrives and there is no bed, arrangements will be made to transfer the client to another shelter where a bed is available.
- The original shelter will work with the new shelter on getting client moved and forwarding case files and inpatient service paperwork.



Possible Inappropriate Discharges to DHS

- If upon arriving to shelter, it is determined that client is in need of emergency medical care, shelter staff will contact EMS for transport to emergency room.
- If a client arrives in a condition different than as described on *Forms 1-3*, and is possibly medically inappropriate for discharge to DHS, the Shelter/Safe Haven Director will contact their Program Administrator.
- DHS Office of the Medical Director will then review the case to determine whether it is medically inappropriate for discharge to DHS.
- The Office of the Medical Director will call the designated inpatient medical facility contact to request further information from the medical facility (*Form 5 – DHS Post-Discharge Review Form*).
- Upon receipt of the completed Form 5, within one business day, the Office of the Medical Director will render a decision as to the individual's appropriateness for shelter/safe haven placement.
 - Note that while the decision is pending the shelter/Safe Haven is responsible for ensuring the client has a bed.

Review of Forms

- Form 1: Screening Form for Shelter and Outreach Referral
- Form 2: Discharge Planning Form
- Form 3: Shelter and Outreach Referral Form
- Form 4: Day of Discharge Form
- *Form 5: Post-Discharge Review Form*
 - *Form 5 is only submitted on request of DHS Office of the Medical Director*

SCREENING FORM FOR SHELTER AND OUTREACH REFERRAL

Please review all of the conditions and check "Yes" or "No" in the boxes provided. If one answers, "No", to any *unshaded* items, among the screening criteria, this patient is medically inappropriate and cannot be referred for shelter or outreach placement.

FORM 1:

DHS Screening Form – Page 1

- “Yes” answers to *unshaded* items indicate patient is appropriate for shelter.
- On the shaded items, a “no” means patient is appropriate for shelter.

CLINICAL CRITERIA **YES NO**

FUNCTIONAL CAPACITY:

ADLs	Able to toilet, bathe, dress, and feed self independently	<input type="checkbox"/>	<input type="checkbox"/>
Catheters	Able to manage, independently, care of indwelling catheters of any sort (e.g., any central line; PICC; suprapubic; PEG)	<input type="checkbox"/>	<input type="checkbox"/>
	Able to manage, independently, care of external catheters (e.g., Foley), including timely replacement of same.	<input type="checkbox"/>	<input type="checkbox"/>
Communication	Able to communicate needs adequately. Able to understand verbal or ASL requests.	<input type="checkbox"/>	<input type="checkbox"/>
Incontinence	Able to manage bowel and/or bladder regimen, independently, without the use of diapers.	<input type="checkbox"/>	<input type="checkbox"/>
Medication Admin	Able to self-administer all medications. Exceptions may be assumed for clients returning to mental health shelters or select special population shelters.	<input type="checkbox"/>	<input type="checkbox"/>
	e.g., IDDM	<input type="checkbox"/>	<input type="checkbox"/>
	Able to self-administer insulin	<input type="checkbox"/>	<input type="checkbox"/>
	Able to monitor and gauge sliding scale insulin requirement	<input type="checkbox"/>	<input type="checkbox"/>
Mobility Impairment	Able to ambulate, independently (canes, crutches, walkers, & wheelchairs permitted)	<input type="checkbox"/>	<input type="checkbox"/>
	Able to transfer, independently (from wheelchair to toilet/bed)	<input type="checkbox"/>	<input type="checkbox"/>
	Able to arise from seated position or from bed (does not require turning/repositioning)	<input type="checkbox"/>	<input type="checkbox"/>
Ostomy care	Able to perform ostomy-related care, independently	<input type="checkbox"/>	<input type="checkbox"/>
Wound care	Able to perform wound care, independently, or requires no more than QD/BID VNS visit (arranged by the hospital). Exceptions include the following:	<input type="checkbox"/>	<input type="checkbox"/>
	Burns	<input type="checkbox"/>	<input type="checkbox"/>
	Incompletely healed or s/p skin grafts, requiring extensive dressing changes/care	<input type="checkbox"/>	<input type="checkbox"/>
	Weeping wounds	<input type="checkbox"/>	<input type="checkbox"/>
	Excessive discharge from wounds, saturating dressings, creating public health risk to others	<input type="checkbox"/>	<input type="checkbox"/>

MENTAL CAPACITY:

Cognitive impairment	Meets criteria for dementia, delirium, or has major cognitive deficits (of any etiology), especially, in areas of immediate/ short-term memory, concentration, and/or ability to learn, due to other neuropsych disorders (i.e. amnesic syndromes, TBI, SDH, CVA, MR, etc.).	<input type="checkbox"/>	<input type="checkbox"/>
Decisional Capacity	Has full decisional capacity re: treatment and disposition decisions	<input type="checkbox"/>	<input type="checkbox"/>



FORM 1:

DHS Screening Form – Page 2

- Immunosuppression
- Clinical criteria
- Vulnerability assessment for street homeless patients
- Statement of appropriateness for shelter

Patient's Name: _____

FORM 1

SCREENING FORM FOR SHELTER AND OUTREACH REFERRAL (continued)

CLINICAL CRITERIA YES NO

IMMUNOSUPPRESSION:

Immuno-competence	Immuno-competent and able to tolerate congregate living conditions, including congregate dining, bathrooms, and dormitories. Exceptions include:	□	□
AIDS	Meets CDC criteria (CD4<200 or opportunistic infection). Refer to HRA HASA.		
Cancer	If extensively metastatic, or if patient is undergoing in/outpatient chemotherapy or radiation, with significant risk of immunosuppression and side effects of treatment		

SPECIFIC CLINICAL CRITERIA:

Arson	Known history of recent fire-setting, especially, if in congregate settings or in response to command auditory hallucinations	□	□
Cranial Halo Devices	Cranial halo device or other stabilizing/protective gear, worn continuously	□	□
Diarrhea	Chronic diarrheal illness or conditions resulting in explosive diarrhea, fecal incontinence, or requiring the use of bedpan/commode	□	□
Diet	Requires regular or ADA diet, only. (Shelters have limited and variable ability to provide renal diets; there is <u>no</u> availability of pureed, soft mechanical, or liquid diets.)	□	□
Medical Equipment	Need for infusion pumps or ventilator	□	□
	Independent in use of all other medical equipment (suctioning devices, nebulizers, etc)	□	□
Oxygen	Adequate saturation on room air.	□	□
	Requires home or portable oxygen.	□	□
Tubes	Free of tubes (e.g. NGT) or drains of any sort (even if they are clamped)	□	□

STREET HOMELESS PATIENTS ONLY: VULNERABILITY ASSESSMENT

Please review all of the conditions and check "Yes" or "No" in the boxes provided; responses can come from hospital records and/or client report.

	Y	N
HIV/AIDS	□	□
Kidney Disease	□	□
History of frostbite, hypothermia or immersion foot	□	□
Chronic liver disease	□	□
Arrhythmia	□	□
Over 60 years of age	□	□
Three or more hospitalizations in the past 12 months	□	□
Three or more ER visits in the past 3 months	□	□

STATEMENT REGARDING MEDICAL APPROPRIATENESS FOR SHELTER

I, _____, the Physician/Nurse Practitioner/Physician's Assistant (circle one), caring for this patient, attest that the answers to the above items accurately reflect the patient's condition. This patient meets all screening criteria, above, and is medically appropriate for shelter or outreach placement.

(Name of Physician/NP/PA)
06/08/10

(Date)

(Contact number)

DHS SHELTER/OUTREACH REFERRALS: DISCHARGE PLANNING WORKSHEET

ATTENTION: DHS requires that all possible placement avenues are explored, prior to discharge, and that a placement or referral to outreach teams is seen as the last resort. For at-risk individuals on inpatient psychiatric units, who are eligible for supportive housing, an HRA 2010e application, psychosocial, and the HRA approval letter are to be completed, for every eligible client, prior to discharge. Refer to the next page for street homeless specific questions. There is also space for notes on the reverse page.

FORM 2:

**DHS Discharge Planning
Worksheet – Page 1**

- Benefits data is very important
- AOT and ICM
- Housing applications
- Efforts to place outside of DHS

Hospital/Facility name	SW/RN/Discharge Planner Contact Name and Phone
Patient Name	HA#/SS#/DIN#

1. Detail nature and course of homelessness, indicating change in living situation, inclusive of dates and timeframes.
2. Document where the patient lived, prior to hospitalization, and why the patient cannot return there. If patient is street homeless, contact the borough's Outreach team to confirm if a client is known to a team, and determine the patient's willingness to go to a shelter. If pt is on Parole or Probation, include Correctional Facility, date of release, period of incarceration, nature of crime, sexual offender status, & OMH risk level.
3. Detail current benefits and list of any applications for the following benefits submitted during this hospitalization.

Medicaid	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Applied <input type="checkbox"/>	Public Assistance	Yes <input type="checkbox"/>	\$ _____	No <input type="checkbox"/>	Applied <input type="checkbox"/>
Medicare	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Applied <input type="checkbox"/>	SSI/SSD	Yes <input type="checkbox"/>	\$ _____	No <input type="checkbox"/>	Applied <input type="checkbox"/>
HRA 2010e (NY NY)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Applied <input type="checkbox"/>	Food Stamps	Yes <input type="checkbox"/>	\$ _____	No <input type="checkbox"/>	Applied <input type="checkbox"/>
Veterans Benefits	Yes <input type="checkbox"/>	No <input type="checkbox"/>	\$ _____					
4. Detail all efforts made to place patient outside the shelter system (i.e., to previous residence, with family or friends in or out of state, in private homes, Supportive Housing, SRO, Nursing Homes, Assisted Living Facilities, State Psychiatric Centers, etc) and provide outcomes and follow-up on all residences for which patient was on waiting lists. Justify if no efforts were made for otherwise eligible individuals. If the patient is street homeless, detail contacts made with outreach teams and plans discussed.
5. If this client was placed under AOT, was the court order received and Citywide ICM requested? Yes No
6. Did patient allow contact with family, friends or community supports? Yes No
If yes, provide full details/documentation of meetings or conversations:
7. If patient was evicted from his/her apartment, provide all of the details around the reported eviction and indicate whether it was a formal eviction. Was the landlord contacted, etc? If this patient is at risk of becoming homeless, was a HomeBase referral made?

FORM 2:

**DHS Discharge Planning
Worksheet – Page 2**

- Referrals to outreach – assessment of street/park/subway chronicity
- Attestation of placement efforts

8. List any housing applications that hospital has submitted, indicating if the patient has an interview scheduled. Attach additional page(s) as needed. If it was difficult to place pt in supportive housing, documented contact with CUCS is required.

9. If patient has advanced HIV disease or AIDS, was the patient referred to HASA? What was the outcome?

10. Detail any involvement with other organizations, departments, or government agencies (i.e., CUCS, APS, ACS, Parole, Brad H, OMH, HASA, HomeBase Prevention, etc.).

REFERRALS TO OUTREACH – FILL OUT FOR STREET HOMELESS INDIVIDUALS ONLY
(This information can be obtained through patient's self-report and/or through hospital records.)

1. Length of time on the Streets/Parks/Subways over last two years:
2. Length of time on the Streets/Parks/Subways over lifetime:
3. Location (Streets/Parks/Subways) where patient sleeps when not hospitalized (as specific as possible):

ADDITIONAL DISCHARGE PLANNING NOTES:

ATTESTATION OF DISCHARGE PLANNING EFFORTS:

The patient's full range of non-shelter housing options has been explored and the Treatment Team has found no viable, safe alternative to shelter for the patient.

Signature of Treatment Team Member

Date

SHELTER and OUTREACH REFERRAL FORM

PLEASE NOTE:
LEGIBILITY IS THE RESPONSIBILITY OF THE REFERRING FACILITY

- RETURNEE: DHS SHELTER CLIENT WITHIN THE PAST YEAR: HA# _____
 - NEW, PREVIOUSLY-DOMICILED INDIVIDUAL (NOT STREET HOMELESS)
 - STREET HOMELESS INDIVIDUAL BOROUGH: _____
- (Please note that only chronic street homeless patients (those on the streets for a minimum of 9 months over the last 2 years), who refuse shelter placement, can be referred to the borough outreach team. Non-chronic street homeless individuals should be referred to shelter, if an alternative option is not identified.)*
- Primary medical inpatient referral
 - Primary psychiatric inpatient referral
 - Detox

I. HOSPITAL AND PATIENT DATA

A. HOSPITAL/FACILITY INFORMATION

Facility Name: _____ Contact Person: _____
Telephone: () _____-_____-x_____ Pager/Cell: () _____-_____
Fax: () _____-_____ Email: _____

B. PATIENT INFORMATION

Name: _____ DOB: ____/____/____ SS#: ____-____-____
Alias: _____ Sex: M F Ethnicity: _____
Prior DHS Shelter Resident: Yes No If Yes, where? _____ Most recent stay? ____/____/____
Expected Date of Hospital/Facility Discharge: ____/____/____
Citizenship: US Citizen Resident Alien Undocumented US Veteran: Yes No
Able to communicate in English? Yes No If No, language spoken? _____
Is patient ambulatory? Yes No
If No, does patient require a Wheelchair? Yes No Cane? Yes No Crutches/Walker? Yes No

Clinic or Private MD where patient receives care: _____
Phone/pager number of PMD/outpatient clinic: _____
Address of PMD/outpatient clinic: _____
Next of Kin: _____ (relationship) Phone: () _____-_____
Emergency Contact: _____ (relationship) Phone: () _____-_____

FORM 3:

**DHS Shelter and Outreach
Referral Form – Page 1**

- Patient data
- Inpatient medical facility
contact info
- Wheelchair needs
- Medical Care Provider
- Next of Kin



FORM 3:

DHS Shelter and Outreach Referral Form – Page 2

- Patient release
- Capacity Statement

II. PATIENT'S RELEASE OF INFORMATION AND STATEMENT OF CAPACITY

A. PATIENT'S RELEASE OF INFORMATION:

I, _____ (name of patient), give permission to the medical and social work staff at _____ (name of hospital), to release the information, below, to the NYC Department of Homeless Services Agency Medical Director's Office, and the Social Services and Medical staff, if any, at my assigned shelter or outreach placement. I understand that this information will be used to help determine if a shelter or outreach placement is an appropriate place for me and, if so, to which shelter or outreach placement I might go. By giving the information to the staff at my assigned shelter or outreach placement, I will be helping them to care for me and to place me into permanent housing more quickly, and avoid having to repeat the blood tests and examinations I have had while I have been in the hospital. I agree to this plan for discharge to a shelter or outreach placement and have rejected, when offered, a more appropriate setting. I understand that I can come into the shelter system without releasing this information. I know that, if I change my mind about releasing this information, I can write or ask someone else to write down this decision and give it to a member of my hospital treatment team. I understand that if the information has already been sent, I cannot ask the hospital to take it back again. I also understand that it is possible that this information will be further disclosed and will no longer be protected. I have a right to a signed copy of this release form. This release is good for three months after my discharge from the hospital.

I permit _____ (name of hospital) to release the following information:

- All information contained or referenced in this Shelter and Outreach Referral Form
- Information regarding my HIV status
- Information regarding my use of drugs or alcohol.

I understand that only the information checked off can be given to DHS.

Patient's Signature: _____ Date: ____/____/____
 Witness: _____ Date: ____/____/____
 (Include title, as appropriate.)

B. STATEMENT OF PATIENT'S CAPACITY

As the Physician/Nurse Practitioner/Physician's Assistant (circle one) primarily responsible for this patient's inpatient care, I assert that the information contained in this document reflects accurately the patient's condition upon admission and hospital course through discharge, and that, in my clinical judgment, this patient has the capacity to decide to be discharged to a shelter or outreach placement. I have explained fully to this patient that a shelter or outreach placement has limited, if any, on-site medical care, no 24-hour nursing care, and limited medication administration. We have offered him/her more appropriate settings, if warranted by his/her medical condition. He/she has, nonetheless, chosen to go/return to a shelter or outreach placement, and, at this time, has full decision-making capacity to do so.

_____/_____/_____ () _____
 (Name of Physician/NP/PA) (Date) (Pager or phone number)



III. ADMISSION AND HOSPITAL COURSE (to be completed by MD/NP/PA only)

DATE OF ADMISSION TO HOSPITAL/FACILITY: ___/___/___

A. REASON FOR ADMISSION, BRIEF HPI, and HOSPITAL COURSE: _____

B. ALLERGIES: Yes If Yes, to what?: _____ No Unknown

C. TB CLEARANCE: Does patient evidence signs or symptoms of active TB? Yes No

♦ TST+/Blood Test for TB: Was TST (PPD) done during this admission? Yes No

If Yes, what were the results? Planted: ___/___/___ Read: ___/___/___ _____ mm
 (date) (date)

➤ If pt has Latent TB Infection (LTBI), NYC DOHMH/CDC protocol mandates that the Provider offer/initiate preventive treatment. Has treatment been initiated? Yes No If No, why not? _____

IV. DISPOSITION PLANNING

A. DIAGNOSES UPON DISCHARGE (include all diagnoses)(to be completed by MD/NP/PA only):

1.	5.
2.	6.
3.	7.
4.	8.

B. MEDICATIONS (to be completed by MD/NP/PA only) (attach additional page, as needed):

Medication (generic name if possible)	Dosage	Route	Frequency*	Dispensed #: **	Comments (last Dec.? TDM + date?)
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					

* Use QD or BID dosing as possible; include dosing for Methadone maintenance (MMTP).

** Document whether medications will be supplied or prescriptions given.

FORM 3:

DHS Shelter and Outreach Referral Form – Page 3

- Admissions data
- Allergies and TB clearance
- Diagnoses
- Medications and dosage



FORM 3:

**DHS Shelter and Outreach
Referral Form – Page 4**

- Special assistance
- Follow up
- AOT/ICM contact info

C. SPECIAL ASSISTANCE NEEDED BY PATIENT UPON DISCHARGE: (to be completed by MD/NP/PA)

♦ Does the patient have a wound? Yes No If Yes, describe: _____

If Yes, does wound require dressing? Yes No
 If Yes, can the patient change the dressing and perform wound care independently? Yes No

♦ Does patient need specific labs or diagnostic procedures/imaging to be repeated while in shelter? Yes No

If Yes, document which test and when it should be repeated: _____

D. SPECIAL FOLLOW-UP NEEDED UPON DISCHARGE:

♦ Does the patient require any special supplies or nursing care upon discharge? Yes No

Item(s)/help provided: VNS dressing changes syringes glucometer other _____

♦ Will patient require any special equipment upon discharge (i.e., wheelchair, cane, walker, etc.)? Yes No
 If Yes, elaborate: _____

E. SPECIAL PSYCH FOLLOW-UP NEEDED UPON DISCHARGE:

♦ Has petition for AOT been submitted? Yes No

♦ Has an order for AOT been issued? Yes No

If Yes, attach copy of original court order and treatment plan, document AOT team (_____) and provide name and number of ICM/ACT team.

 Name ICM/ACT Team (_____) _____
 Phone Number

♦ Will patient receive Koskinas follow-up? Yes No (For HHC patients, only)

If Yes, provide name and number of Koskinas worker.

 Name (_____) _____
 Phone Number

If No, why not? _____



PATIENT'S NAME: _____ SHELTER: _____

Please fax to placement/intake site on the day of discharge FAX NUMBER: _____



DISCHARGE FORM FOR SHELTER PLACEMENT and OUTREACH REFERRAL

A. UPDATE OF MEDICATIONS UPON DISCHARGE (to be completed by MD/NP/PA only):
Please note only new medications or changes in medications or dosing compared with original referral.

Medication (generic name, if possible)	Dosage	Route	Frequency*	Disp. #**	Comments (last Dec.? TDM + date?)
1.					
2.					
3.					
4.					

* Use QD or BID dosing as possible; include dosing for Methadone maintenance (MMTP).
** Document whether medications will be supplied or prescriptions given.

If patient is uninsured, will s/he be supplied with medication? Yes No If Yes, for how many days? _____

B. APPOINTMENTS SCHEDULED FOR MEDICAL AND PSYCHIATRIC FOLLOW-UP:
(Please provide actual appointments or times patient may access clinic without an appointment.)

Service	Date	Time	Clinician or Purpose of Visit	Clinic/Location
MEDICAL:				
SURGICAL:				
PSYCHIATRIC:				
OTHER:				
			MMTP	
			VNS (Agency)	Phone: _____

POST-DISCHARGE CONTACT NUMBER: () - _____ for _____ MD/NP/PA

POST-DISCHARGE CONTACT NUMBER: () - _____ for _____ SW/RN/DP

POST-DISCHARGE CONTACT NUMBER: () - _____ for _____ ICM/SCM/ACT Team

POST-DISCHARGE CONTACT NUMBER: () - _____ for _____ Koskinas Worker

SIGNATURE OF CLERK UPON PATIENT'S DISCHARGE _____

FORM 4:

DHS Day of Discharge Form

- Medication updates upon discharge
- Follow up appointments
- Contact info for doctor, social worker/treatment team, ICM/SCM ACT team, and Koskinas worker, if appropriate



POST-DISCHARGE REVIEW FORM

I. HOSPITAL AND PATIENT DATA

A. HOSPITAL/FACILITY INFORMATION

Facility Name: _____ Contact Person _____
 Telephone: () _____ x _____ Pager/Cell: () _____
 Fax: () _____ Email: _____

B. PATIENT INFORMATION

Name: _____ DOB: ___/___/___ SS#: ___-___-___
 Discharge Date: _____ Discharged to: _____

II. POST-DISCHARGE CLINICAL CONCERN(S) and FOLLOW-UP ACTIONS

A. CONDITION(S) OF CONCERN:

B. FOLLOW-UP ACTION(S):

- 1.
- 2.
- 3.
- 4.
- 5.

C. REVISED DISCHARGE PLAN (if applicable)

Service	Date	Time	Clinician or Purpose of Visit	Clinic/Location

Signature of Treatment Team Member

Date

Fax completed form to Dova Marder, MD, Agency Medical Director, NYC DHS

Fax: 1-917-637-7372

06/08/10

FORM 5:

DHS Post-Discharge Review

•If requested, to be submitted to DHS Office of the Medical Director by inpatient medical facility



Contacting Shelters/Safe Havens/Outreach Teams

- The DHS Office of the Medical Director provides, on a quarterly basis, to the Greater New York Hospital Association the contact information for shelters/safe havens/outreach teams, to be distributed to its members Directors of Medical and Psychiatric Social Work, for use in the referral process.
- The referral process and forms are available on the DHS and GNYHA websites.

DHS website - www.nyc.gov/dhs

GNYHA website - www.gnyha.org



Questions/Concerns

Contact DHS Office of the Medical Director