Volunteers of America LOS ANGELES

Avalon Recuperative Care

REFERRAL FORM

6816 S. Avalon Blvd., Los Angeles, CA 90003
Office: 213-205-3315 | Fax: 213-789-5963
Referral Emails: AvalonRecuperativeCare@voala.org

Patient Full Name: Last: _____ First: _____ Patient Contact Number: _____	Date of Birth: _____	How Many Days is Patient Authorized in Recuperative Care? ◯ 14 ◯ 30 ◯ 60 ◯ 90
ReferringHospital/Facility:		
Date of Referral:	Name of Referring Party:	
Phone Number of Referring Party:	Name of attending Physician:	
Emergency Contact Name:	Phone Number:	
Type of Insurance: _____	Insurance Number: _____	Gender Expression: _____
Reason for most recent hospitalization:		
Discharge Medication/dosage/frequency:		
Any food or medication allergies:		
Any diet restrictions:		

Additional Notes:

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Admission Criteria			
Criteria	Yes	No	N/A
Homeless, in the process of becoming homeless, or currently lives in an inappropriate setting for post-hospitalization recovery	☐	☐	☐
Able to complete all ADLs	☐	☐	☐
Able to properly and safely use DME independently Type of DME: _____	☐	☐	☐
Ambulation of at least 50ft prior to hospital (with or without DME)	☐	☐	☐
Able to self-administer medication with minimal staff oversight	☐	☐	☐
Continent of both bladder and bowels (if briefs or diapers are used, the patient must be able to change and maintain hygiene completely and independently)	☐	☐	☐
Medically and psychiatrically stable	☐	☐	☐
Alert and oriented (Name, Place, Date, and Situation)	☐	☐	☐
Any wounds? If yes: Stage 1 ☐ Stage 2* ☐ Stage 3* ☐ Stage 4* ☐ *Will require a Home Health Referral	☐	☐	☐
Danger to self or others	☐	☐	☐
Any specialized care or equipment: CPAP, special bed/mattress, wound care, detoxing, etc. (Please inform nursing staff prior to acceptance)	☐	☐	☐

Please attach:

☐ H & P ☐ PT Notes

☐ Facesheet ☐ Psych Notes

Admission Criteria Met?

Yes ☐ No ☐ Explain: _____