COMMUNITY OUTREACH SERVICES
1740 Eastchester Road
Bronx, New York 10461
Phone (718) 518-2300 Fax (718) 518-2670

ADMISSION: (Please check one)
Today □
Tomorrow □
Backup □
Interim Home Services □ Yes □ No
Copy of Advance Directives Provided □ Yes □ No

Application for: (*Check where applicable*):
Acute Inpatient Admission:
□ Bronx Campus □ Brooklyn Campus

Calvary @ Home:
□ Hospice at Home □ Home Care
Tentative Discharge Date ___/___/___

Ambulatory Services:
□Outpatient Services □Center for Palliative Wound Care

Section A

PATIENT NAME____
First Name Last Name

Address:____________________ Apt. # _____ City __________ State ___ Zip ______

Phone: (______)__________Age____Birth Date:____/____/____Sex____Race___Rel________Marital Status________

SS#________-______-________Medicare________________Medicaid________________

Ins. Co.____________________________Policy #________________

Other Insurance Information____________________________________

Section B

#1 Contact Name________________________Relationship__________□ HCP □ POA □ Advance Directives
First Name Last Name

Address:________________________Apt. #_______City____________State___Zip________

Home Phone: (___)____________Cell Phone: (____)____________Work Phone: (___)____________

#2 Contact Name________________________Relationship__________□ HCP □ POA □ Advance Directives
First Name Last Name

Home Phone: (___)____________Cell Phone: (____)____________Work Phone: (___)____________

PHYSICIAN NAME:____
Physician Agrees with Transfer to Calvary Hospital? □ Yes □ No

Physician Address:________________________City____________State________Zip________

Phone: (____)__________Fax: (____)____________Beeper: (____)__________Cell: (____)__________

SW/CM/DCP NAME:____________________________Beeper: (____)__________#________

Phone: (____)__________Ext:________Fax: (____)____________Nursing Unit Phone: (____)__________

Facility/Program:________________________________**Patient Admit Date:**____/______/______

Completed by Signature:________________________Print:__________________Date:________

Section C

DIAGNOSIS:____________________________**/ALLERGIES:**________________________
Mets: □ Lung □ Liver □ Brain □ Bone □ Other:________________________________
Current Medical Issues/Intensity of Service

□ PCA
□ Oxygen □ Shortness of Breath
□ BIPAP/ Settings: ____________
□ Nausea/Vomiting
□ Diarrhea
□ Constipation
□ Seizure
□ Pathological Fracture
□ TPN/PPN

□ Cord Compression
□ Hemorrhage/Bleeding________________
□ Infection □ Isolation
□ Cardiac Arrhythmias
□ Psychiatric Dx________________
□ History of Wandering
□ History of Falls
□ Restraints
□ Pain Control

□ Drains/Tubes/Central Lines/Port
□ Anxiety □ Agitation □ Confusion
□ Complex Wound Care □ Fistula
□ Endocrine Disorders
□ Inadequate PO/IV Fluids Therapy
□ Fluid and Electrolyte Disorder
□Chemo/Radiation Therapy (Current/Past)
□ Radiation Implant (Current/Past)
□ Active/Curative Treatment

OTHER:____

Patient Name:______________________________

SS #:______________________________

Date:______________________________

Section D

CURRENT MEDICATIONS: ***(Please attach Medication Listing and Physician Orders and Wound Care orders with application)***

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COMMUNICATION NEEDS:______________________________

Patient and/or Family in agreement with Calvary Hospital Scope of Care (Symptom Management/Basic Life Support) □ Yes

□ No (indicate reason)______________________________

DNR □ Yes □ No

Family Issues______________________________

Patient lives with ______________________________

Application Completed by Signature:____________________Print:______________Date:________

Application for Acute Inpatient Care for Symptom Management Related to Advanced Cancer, Home Care, Hospice at Home and Outpatient Clinic Services

1. **Complete application as soon as possible and fax to the Calvary Outreach Department at (718-518-2670) Monday to Friday 8:30 a.m. to 5:00 p.m.**
    - **The *entire* application must be completed for all referrals.**

2. **Complete insurance information is appreciated to offset delays due to precertification requirements. If known, please provide us with the MCO Case Manager's name and telephone number. For Oxford and HIP MCO Medicare, the facility must call in the referral for *ACUTE END OF LIFE CARE.***

3. **Patient/Families need to understand that resuscitation is limited to basic CPR. If a patient or family requests or expects additional life support measures, we will call 911 and transfer the patient to the nearest emergency department.**