



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

ADMISSION: (Please check one)
Today [] Tomorrow [] *Hold/Backup []
REHAB [] ANTIBIOTIC TX []
WOUND CARE SERVICE [] DNR [] Yes [] No []
Interim Home Services [] Yes [] No []
Copy of Advance Directives Provided [] Yes [] No []
DNR [] Yes [] No [] (Attach Copy)

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 Medicaid Office Phone #

Section B

#1 Contact Name First Name Last Name Relationship [] HCP [] POA [] Advance Directives
Address: Apt. # City State Zip
Home Phone: () Cell Phone: () Work Phone: ()
#2 Contact Name First Name Last Name Relationship [] HCP [] POA [] Advance Directives
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 PLEASE FAX MEDICATION RECONCILIATION LIST

DIAGNOSIS:
/ALLERGIES:

Mets: [] Lung [] Liver [] Brain [] Bone [] Other: DNR [] Yes (attach a copy) [] No
Current Medical Issues/Intensity of Service
[] PCA [] Cord Compression [] Drains/Tubes/Central Lines/Port
[] Oxygen [] Shortness of Breath [] Hemorrhage/Bleeding [] Anxiety [] Agitation [] Confusion
[] BIPAP/ Settings: [] Infection Type of Infection [] Complex Wound Care [] Fistula
[] Nausea/Vomiting [] Isolation Type of Isolation [] Endocrine Disorders
[] Diarrhea [] Constipation [] Cardiac Arrhythmias [] Inadequate PO/IV Fluids Therapy
[] Restraints [] Psychiatric Dx [] Fluid and Electrolyte Disorder
[] Seizure [] History of Wandering [] Chemo/Radiation Therapy (Current/Past)
[] Pathological Fracture [] History of Falls [] Radiation Implant (Current/Past)
[] TPN/PPN [] Pain Control [] Active/Curative Treatment

OTHER:
*REASON FOR HOLD\B/U:



Patient Name: _____
SS #: _____
Date: _____

Section D

CURRENT MEDICATIONS:

NOTE: PLEASE FAX A PRINT OUT OF THE MEDEX, IF AVAILABLE.
(Please attach Medication Listing, Physician Orders and Wound Care orders with application)

COMMUNICATION NEEDS:

Patient and/or Family is in agreement with Calvary Hospital Scope of Care (Symptom Management/Basic Life Support)
 Yes No (indicate reason) _____

DNR Yes (Please Provide a Copy) 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.