Recuperative Care Referral Form

Inland Bridge Recuperative Care, LLC · DBA Inland Bridge Residences · NPI 1548160211
Phone/Text (909) 559-4062 · Colton (men) · Fontana (women)

Fax completed form and records to: [FAX NUMBER - pending]

1. Referral

Referral date | Time | Discharge today? (Y/N) | Anticipated discharge date | Preferred home

2. Referring partner

Name | Title / role | Organization / facility

Unit / department | Phone / ext. | Fax | Email

3. Member

Last name | First name | Date of birth | Gender | Preferred language

Interpreter needed? (Y/N) | Medi-Cal CIN | Health plan | Plan member ID

Authorization status

☐ Not yet requested ☐ Requested (pending) ☐ Approved

Authorization # | Authorized from | Authorized to | ECM provider (name / phone)

Current location

☐ Inpatient ☐ Emergency dept. ☐ SNF / rehab ☐ Community / clinic ☐ Other

Housing status

☐ Unsheltered ☐ Shelter ☐ At risk of homelessness ☐ Unstable / unsafe housing

4. Clinical summary

Primary diagnosis | Secondary diagnoses

Why does the member need recuperative care? (recovery goal and expected length of need)

Allergies | Projected length of need

Follow-up appointments (provider, date, time)

CONFIDENTIAL: contains protected health information. If received in error, notify (909) 559-4062 and destroy. We do not need the member's SSN.

5. Safety screen (our homes are unlicensed; residents must manage their own daily care)

Independent with all ADLs	○ Yes	○ No	Able to self-evacuate in an emergency	○ Yes	○ No
Ambulatory (with or without own device)	○ Yes	○ No	Continent or self-manages supplies	○ Yes	○ No
Self-administers all medications	○ Yes	○ No	Oriented; makes own decisions	○ Yes	○ No
Dementia / Alzheimer's history	○ Yes	○ No	Fall in the last 30 days	○ Yes	○ No
Wound care needed (self-managed?)	○ Yes	○ No	Oxygen (self-managed?)	○ Yes	○ No
Needs IV, injections or tube feeding	○ Yes	○ No	Isolation precautions currently	○ Yes	○ No
Behavioral health diagnosis	○ Yes	○ No	Currently in behavioral health care	○ Yes	○ No
Current suicidal / homicidal ideation	○ Yes	○ No	Substance use in last 30 days	○ Yes	○ No
Withdrawal symptoms / needs detox	○ Yes	○ No	On MAT (methadone / buprenorphine)	○ Yes	○ No
Registered sex offender (PC 290)	○ Yes	○ No	Uses cane / walker / wheelchair	○ Yes	○ No

TB screen / chest X-ray date and result

Mobility device, oxygen, diet or other details

Behavioral health / substance use notes (diagnosis, stability, current provider)

6. Records attached (fax with this form)

- ☐ Face sheet
- ☐ Medication list / MAR
- ☐ PT / OT notes
- ☐ Other
- ☐ History & physical
- ☐ TB screen / chest X-ray
- ☐ Wound-care instructions
- ☐ Discharge summary / orders
- ☐ Recent progress notes
- ☐ Behavioral health notes

Number of pages including this form

Other records (describe)

7. Referrer attestation

I confirm the member has agreed to this referral and the information above is accurate to the best of my knowledge.

Printed name

Signature

Date

What happens next

1. Our nurse reviews the packet against our Admission Criteria (inlandbridge.com/admission-criteria).
2. We respond to hospital referrals the same day whenever possible, and to all other referrals within one business day.
3. We confirm Medi-Cal eligibility and health plan authorization, the home and bed, and the arrival time. We provide transportation.
4. If we cannot accept the referral, we tell you why and suggest a better-fit level of care.

For Inland Bridge use:

Received (date / time)

Reviewed by

Decision (accept / decline / pending)

Bed / home

CONFIDENTIAL: contains protected health information. If received in error, notify (909) 559-4062 and destroy. Not a licensed care facility.