RECUPERATIVE
CARE CENTER

Lynn Community health center

Please fax referral to the Admissions Department at **(781) 691-9486 (f)**
Follow-up with a **phone call** and check on status of referral at **(781) 691-9483 (p)**

Bridgewell

Patient Name: _____	**Facility/Hospital:**_____
DOB:_____	**Contact Name:**_____
Insurance Carrier:_____	**Contact Number:**_____
Psychiatric F/U: _____	**PCP Name**:_____

Acute Medical Need/ Reason for Referral: _____
Primary diagnosis: _____
Substance Use and/or Psychiatric Diagnosis: _____

Required Admission Criteria
- ☐ Homeless in city of Lynn
- ☐ Has an acute medical condition
- ☐ Independent with all ADLS
- ☐ Independent with mobility
- ☐ Continent of urine and feces
- ☐ Behaviorally appropriate for group setting
- ☐ Fever/ diarrhea past 24 hours **YES** **NO**

Anticipated Patient Needs
- ☐ Wound care
- ☐ Dialysis (clinic name and location: _____)
- ☐ Uses assistive device (type: _____)
- ☐ Bariatric equipment
- ☐ Methadone maintenance therapy *(fill out confirmation sheet attached)/* MAT Treatment
- ☐ Foley/ ostomy *(include equipment information)*
- ☐ Oxygen required. YES NO
- ☐ COVID (HX of) Tested? YES. NO IF YES DATE TESTED _____
- ☐ Precaution room

Contact (C-diff) Droplet (influenza)

Please attach the following paperwork required for screening:
- ☐ History and Physical (H&P)
- ☐ Current medical list
- ☐ Provider progress notes (most recent)
- ☐ Nursing progress notes (most recent)
- ☐ Current lab values

If applicable:

☐ Psych & social consults	Attached	Not applicable
☐ PT/OT notes (most recent)	Attached	Not followed
☐ Methadone confirmation	Attached	Not on methadone maintenance

☐ I verbally authorize the Recuperative Care Center (Lynn Community Health Center) to receive and release information from or to Bridgewell. Pt will sign hard copy upon admittance to Recuperative Care Center