Office of Homeless Services
CITY OF PHILADELPHIA

External Agency Referral form

Agency information

Hospital/agency name: _____

Date: | | | | | | | | |
MM DD YYYY

Referrer's name: _____

Referrer's phone number: | | | | | | | | | | |

Admission

Date of admission: | | | | | | | | |
MM DD YYYY

Date of discharge: | | | | | | | | |
MM DD YYYY

Reason for admission: _____

_____

Where did the participant live before admission?

_____

Other family needing shelter with participant:

_____

_____

_____

Identifying information

Participant name: _____

Participant Social Security number: | | | | | | | | | | |

Participant date of birth: | | | | | | | | |
MM DD YYYY

Patient gender (assumed): ☐ Female ☐ Male ☐ I'm not sure

Health information

Does the participant

- Have a Behavioral Health Intensive Care Manager (ICM)?
  ☐ Yes ☐ No

  If yes, is the ICM part of the discharge planning?

  ICM name: _____

  ICM phone number: | | | | | | | | | | |

- Have a mental health diagnosis? ☐ Yes ☐ No

  If yes, please specify the diagnosis:

  _____

- Have a substance abuse disorder? ☐ Yes ☐ No

  Has the participant taken a Urine Drug Screening (UDS)?
  ☐ Yes ☐ No

- Have continence issues? ☐ Yes ☐ No

  OHS cannot accept patients who are incontinent, unless they are totally self-sufficient.

- Have any open wounds? ☐ Yes ☐ No

  OHS cannot accept patients who have open wounds requiring ongoing wound care.

- Have dementia? ☐ Yes ☐ No

- Have any arson charges? ☐ Yes ☐ No

- Manage all ADLs? ☐ Yes ☐ No

- Need assistance to ambulate? If yes, check one:

  ☐ Cane ☐ Crutches ☐ Wheelchair ☐ Walker

Is the participant Foley/Oxygen/Colostomy dependent?

☐ Yes ☐ No

If yes, please explain:

_____

_____

_____

Last updated: October 2019