Hospital to Home Alliance of Ventura County

Clear Form

Transfer to Acute Care from Home Health

This patient is on active service with (agency)_____

Patient_____ **DOB**_____

Hospital_____

PCP _____ **Other Physician**_____

Current home health episode dates _____ to _____

Disciplines on service ☐ RN ☐ PT ☐ OT ☐ MSW ☐ST ☐ HHA ☐ Other_____

Cause of transfer to Acute Care (per patient, family, HHA)

_____

_____

Person Home Health is communicating with/the patient's designated representative or contact person.

Name _____ **Phone #**_____

☐ Consider hospital MSW evaluation. Please provide more details below.

_____

_____

☐ Consider Palliative Care Referral. Please provide more details below.

_____

_____

☐ APS referral made. Please provide more details below.

_____

_____

☐ **HIGH RISK PATIENTS.** Please provide more details below.

_____

_____

☐ Medication profile attached.

☐ Additional information attached.

This form should be hand delivered to the appropriate hospital so a face-to-face conversation may occur. If a face-to-face conversation is delayed, this form should be emailed to the appropriate hospital to the following email addresses.

CMH
jyamabe@cmhshealth.org
gnunez@cmhshealth.org
lreeder@cmhshealth.org
mbarry@cmhshealth.org

Ojai Valley
hpriddy@cmhshealth.org
csnowbarger@cmhshealth.org

SJCH
sjcasemanagement@commonspirit.org

SJRMC
sjcasemanagement@commonspirit.org

SPH
laura.zarate@ventura.org

VCMC
laura.zarate@ventura.org