



**Admission Referral Form  
For Special Needs Patient: Bariatric**

Referral Date: \_\_\_\_\_ Referring Facility: \_\_\_\_\_

Patient/Resident Name: \_\_\_\_\_ DOB: \_\_\_\_\_

SS#: \_\_\_\_ - \_\_\_\_ - \_\_\_\_\_ MC#: \_\_\_\_\_

Address: \_\_\_\_\_  
Mailing Address City State Zip Codes

Daytime Phone: \_\_\_\_\_ Message Phone: \_\_\_\_\_

Expected LOS: \_\_\_\_\_ Provider: \_\_\_\_\_

Patient BMI: \_\_\_\_\_ Weight: \_\_\_\_\_ Height: \_\_\_\_\_

**Emergency Contact Information**

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Address: \_\_\_\_\_  
Mailing Address City State Zip Codes

The following sections are to be filled out by PT/OT or Admitting Nurse and/or social worker.

**1. Equipment**

- a. Does the patient have their own equipment?  Yes  No
- b. If so, what equipment? \_\_\_\_\_
- c. Does the equipment meet the needs of the patient?  Yes  No
- d. Does the facility have the right equipment to meet the patient's needs?  Yes  No
- e. Will the patient require equipment or services that North Valley Hospital cannot provide?  
 Yes  No

**2. Functional Ability**

a. **Past functional ability (past three months):** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**b. Current functional ability**

i. **Transfers:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

ii. **Balance:** \_\_\_\_\_

\_\_\_\_\_

iii. **Sensory/Motor:** \_\_\_\_\_

\_\_\_\_\_

iv. **Strengths:** \_\_\_\_\_

\_\_\_\_\_

v. **Other Limitations (i.e. Gait, Bed Mobility, etc.):** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

vi. **Cognitive Memory:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

vii. **Social Support:** \_\_\_\_\_

\_\_\_\_\_

viii. **Family support when return to home:** \_\_\_\_\_

\_\_\_\_\_

ix. **Needed support to live in community:** \_\_\_\_\_

\_\_\_\_\_

**3. Staffing**

Will the patient's healthcare needs exceed the abilities of the available staff to deliver care safely? (*Refer to functional ability and current staffing*)     **Yes**     **No**

**4. Other Factors for Consideration**

Is there Financial Resources available to help meet specialty needs?     **Yes**     **No**

\_\_\_\_\_

**Admission recommendations and signatures from involved disciplines:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Signature:** \_\_\_\_\_                      **Date:** \_\_\_\_\_

**Signature:** \_\_\_\_\_                      **Date:** \_\_\_\_\_