EH Referral *Form*

For medical referrals, please send the referral and any medical forms to emergencyhousingreferrals@desc.org and to Nurse Angie angels39@uw.edu

Once form is completed, email back to: emergencyhousingreferrals@desc.org.

Referral Information		
Today's Date:		
Current Time:		
Referring Agency:		
Staff Name:		
Program Name:		
Role / Title:		
Contact Phone #:		
Client Name:		
DESC CHASERS # or DOB:		
VAT Score:		**Must include VAT, if no VAT *within the last year* pages 3-5 must be completed**
Admission Date:		
Admitted for:		
Demographics		
Race:		
Sexual Orientation:		
Gender Identify:		

Screening Checklist	Yes	No
Have you yourself met with this person within the last 48 hours?		
- (If no to the question above, when was the last time you met w/ the client face to face?")		
Can this person perform activities of daily living? Showering, toileting, dressing, etc.		
Is the person ambulatory? - "Person must carry all belongings in a single trip."		
Does person use mobility device?		
Can the person take medications, obtain meals outside of the shelter, and attend scheduled appointments independently?		
Is the person oriented to time, place and person?		
Can the individual transfer from a cot and/ or mat on the floor without assistance?		
Is an engagement plan in place for this client which needs additional clinical support to remain stable?		
- If no to the question above, how often will the client need to be engaged weekly?		
Does the client and team understand that this is not a medical or care facility, we do not provide medical beds, and medications must be managed independently? - Beds are not guaranteed upon recommendation. - Placement will be based upon vulnerability and space available.		
A "no" answer may indicate that the client is not currently within scope for our programs.		

Screening Checklist	Yes	No
Are they experiencing flu like symptoms?		
Have they tested positive and/or had direct exposure to COVID-19 positive individuals in the last 14 days?		
Does the person have a history of Traumatic Brain Injury or symptoms of dementia?		
- If yes to the question above, please describe:		
Does the person use a colostomy, urinary catheter, or require tube feeding?		
Does the person have specialized treatment needs such as dressing changes, special diet, supplemental oxygen, etc.? - *daily dressing changes cannot be accommodated*		
Does this client have a partner that stays at MPI or HTH Northgate?		
- If yes to the question above, is there a history of DV or any other issues that we should be aware of?		
A "yes" answer may indicate that the client is not within scope for our programs. The referral must be approved by medical personal or manager.		

Please provide a description of the client's vulnerability by utilizing the following categories. If the client has a current and accurate VAT, attach it to the referral instead. A current VAT means that it was dated no longer than 1 year ago. If it is a provisional VAT, then it should be no longer than 6-months ago.

The questions following each category are to give an idea of what types of information we are looking for. They are not intended to limit the scope of information pertaining to an individual's vulnerability. If there is additional information you feel would help reflect their vulnerability you are encouraged to include it. The more information you are able provide the clearer picture we will have of their vulnerability. Please DO NOT answer yes/no.

If you have questions on how to fill out this document please contact Emergencyhousingreferrals@desc.org.

Survival Skills
- *Are they frequently taken advantage of? Have they had their EBT or Direct Express cards stollen? If they have someone go purchase items, do they provide their card and PIN#?*

Basic Needs
- *Are they able to meet their needs pertaining to food, clothing, hygiene, and income?*

Medical Risks
- *Please give information related to their medical needs such as diabetes, heart disease, shortness of breath, incontinent of urine or stool, hearing, or visual impairments. Are they able to maintain their own medications?*

Organization/Orientation
- *Are they able to maintain attention, keep track of appointments, maintain awareness of their surroundings, or do they have a memory deficit? Do they have a developmental disability, dementia, or TBI?*

Mental Health
- *Do they have any issues related to mental health? If so, what are they? Are they willing to engage with a mental health provider?*

Substance Use
- *What are their drugs of choice? What are their methods of consumption? (injection, inhalation, ingesting) How long have they been using? Do they have insight into the effects of their drug use?*

Communication
- *Is there a communication barrier? Is there a physical impairment? Are they non-verbal? Oris there a language barrier?*

Social Behaviors
- *Are they able to walk away from a hostile situation? Do they have a history of predatory behavior or being the victim of predatory behavior? Is their baseline response angry or profane? Do they exhibit an inability to cope with stress? Have their social behaviors resulted in an arrest?*

Homelessness
- *How long have they been homeless? Is this their first instance of homelessness?*