



Eagle's Wings Coordinated Care
Order Form for Medical Respite Services CPT Code T2033

Fax: 360-627-8340 Attn: EWCC Medical Respite Referral Line: 360-801-7039

Patient Name: Patient DOB:

Primary Insurance: Insurance ID #:

Provider One #:

Secondary Insurance: Insurance ID #:

Referring Provider Name:

Referring Provider NPI #: Referring Provider Tax ID #

Referring Health Care Facility & Address:

Agency Contact for Referral: Name/Phone/Email/Fax:

Description of Medical Condition Requiring Medical Respite (attach notes if needed):

Diagnosis & ICD-10 Code:

Number of Days Needed for Recovery per Provider Orders: Date of discharge:

Printed Name of Medical Provider Signature of Medical Provider Date
(MD, DO, ARNP, PA-C) (MD, DO, ARNP, PA-C)

Eagle's Wings Medical Respite Staff Only

Is the patient cleared for Medical Respite? Yes No
Yes, Intake approved for / / for days.
No: Not Eligible to Return to EWCC No beds available
Inappropriate level of care for EWCC MR; Reason:
Referred to:
Patient did not arrive to MR from referring agency

EWCC Medical Respite Staff Signature & Date



Eagle's Wings Coordinated Care Medical Respite Application

Referral Date: _____

Patient Full Name: _____

DOB: ____/____/____ Age: _____ Sex at birth: M / F Preferred gender Pronouns _____

Phone: _____ Primary Language spoken _____ Ethnicity _____

Medical History:

Medical & Mental Health Diagnoses (Ok to Attach Diagnoses List):

Primary Care, Mental Health, & Specialist Providers (please include contact information and upcoming appointments):

Recently discharged from Inpatient Mental Health Treatment? Yes / No

If yes, Provide the Following: Name of Facility, Dates of Admission/Discharge & Reason for Admission

Does Patient Use any Assistive Devices? Yes / No (if yes please describe/attach orders for DME if needed):

- Walker _____
- Wheelchair _____
- Cane _____

Is the Patient Incontinent? Yes / No Urine ____ Fecal ____

If Yes, list Supplies &/or Accommodations Needed: _____

Is the Patient Independent with Activities of Daily Living? Yes / No
(If no, describe Limitations & Accommodations Needed):

Medication Names and Dosing (Attach Medication List if needed):

Pharmacy: _____

Are there any other medical or behavioral issues that we should be aware of? Yes / No (If yes, please explain):

Substance Use History:

Primary Substance: #1 _____ #2 _____ #3 _____

Last Date Used: #1 _____ #2 _____ #3 _____

Last CIWA Score and Date: _____

Attending recovery-based self-help groups? Yes / No ; Where? _____

Recently discharged from Inpatient SUD Treatment? Yes / No

If yes, Provide the Following: Name of Facility, Dates of Admission/Discharge & Reason for Admission

Is the Patient in Outpatient Treatment? Yes / No

If yes, name of Facility/Counselor/Upcoming appointments:

Housing Status (Patient must qualify as homeless in Kitsap County to qualify for respite):

Mailing Address: _____

City: _____ County: _____

___ Shelter Name: _____

___ Tent ___ Vehicle ___ Camper ___ Couch Surfing

___ Other (please describe) _____

Transportation:

- Independent/Drives own Vehicle
- Access (Attach application if recently submitted but not yet approved)
- Paratransit (Attach application if recently submitted but not yet approved)
- Other: _____

Family Composition:

Pregnant: Yes / No / Maybe Due date: _____

Children: Yes / No Housing Status of Children: _____

Age/Gender: Child 1: _____/_____ Child 2: _____/_____ Child 3: _____/_____

Does the Patient have an open CPS case? Yes / No

Financial:

Patient monthly income: _____

Employed: Yes / No | Full-time / Part-time Employer: _____

Unemployment benefits? Yes / No Veteran's benefits? Yes / No

Public Assistance: Yes / No

- SSI/SSDI
- TANF
- HEN
- Other (Ex: Family/Friend/Church/Tribe) _____

No Income: Yes / No (If no please attach application for public assistance or describe where the patient is in the process)

Legal History:

Incarceration History (where, reason, dates):

Is the Patient in a Therapeutic Court Program? Yes / No (If yes please describe):

Current/Pending Legal Obligations:

Court Dates:

Registered Sex Offender? Yes / No

Probation? Yes / No If Yes, Probation Officer: _____

Warrants? Yes / No If Yes, What & where are they? _____

No Contact Orders? Yes / No If Yes, With whom? _____

If the patient is not at your facility, what is the best way for us to contact and/or find them?

Is there any other information about this patient you think would be helpful to know?

Printed Name Caseworker

Signature Caseworker

Date



Eagle's Wings Coordinated Care

Consent for Release of Information

I, _____ of _____
(Print Name) (County)

Authorize Eagle's Wings Coordinated Care, to disclose and/or receive information from:

Agency/Person(s) Name: _____

Address: _____

City/State/Zip code: _____

Phone #: _____ Fax #: _____

Email address: _____

I understand that the purpose of this release is to allow Eagle's Wings to exchange information about me in any form including verbal, written, and electronic with the above named entity in order to facilitate appropriate treatment, medical care, and monitoring. I also understand that if I decline to sign this release, no information will be exchanged at any time.

Types of information that may be shared include, but are not limited to:

- Substance abuse history, legal issues, and license status
- Diagnostic impression, symptomology and treatment recommendations or services
- Medical and/or psychiatric conditions
- Prescribed medications
- Results of urine, hair, blood, etc. testing
- Program compliance and status

I understand that my records are protected under the Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent. I may revoke this consent at any time except to the extent that action has been taken in reliance on it and that in any event this consent expires automatically as follows:

Specification of the date, event, or condition upon which the consent expires: **(Initial One)**

- _____ Ninety (90) days from the date listed below
- _____ Ninety (90) days after program completion
- _____ Other (specify length of time) _____

Signature

Date