



**Inpatient Rehabilitation Screening Information Request**

**Centralized Admissions and Referrals Office (CARO)**

**Telephone: (562) 385-6554**

**Fax: (562) 385-7590**

Patient Name: \_\_\_\_\_ Diagnosis: \_\_\_\_\_  
 Contact Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
 Referring Hospital: \_\_\_\_\_  
 Room Number: \_\_\_\_\_ Nurse’s Station Phone Number: \_\_\_\_\_  
 Isolation Status: \_\_\_\_\_ Allergies: \_\_\_\_\_  
 Height/Weight: \_\_\_\_\_ Restraints or Sitter needed?: \_\_\_\_\_

To expedite the referral review process, please submit items 1-4 – at a minimum. Additional supporting materials may be requested. Please call our office with any questions.

- 1. Face Sheet**
- 2. History & Physical**
- 3. Last 3 days of physician’s progress notes**
- 4. Therapy evaluation *and* most recent progress notes (PT, OT, Speech; including any weight bearing restrictions)**
5. Pertinent consults (i.e. Operative, Cardiology, Endocrinology, GI, Neurology, Orthopedic, Psychiatry notes, etc.)
6. Radiology reports from CT scans, MRIs, and X-rays
7. Current medication record
8. Vital signs, wound care documentation, isolation status (organism and latest culture report, if applicable)
9. Current labs
10. Dietary restrictions / Need for modified food or drink consistency

Thank you for your referral!

Comments:

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