

REFERRAL PROCESS

- To submit a referral, fax the appropriate information to:
 SAU Fax: 805.389.5951
- If you have questions or wish to give a heads up to the clinical liaison, please call 805.389.5956.
- 1) Upon receipt of your referral, pertinent clinical and funding information is reviewed.
- 2) Next steps are then determined.
 - \Rightarrow If the patient appears to be appropriate for our unit, an onsite clinical evaluation is scheduled.
 - \Rightarrow In most cases, the clinical evaluation can be scheduled within 24 to 48 hours after the referral is made.
- 3) Families are an integral part of the treatment team at the SAU level of care. We encourage them to be active participants in their loved one's stay. Therefore...
 - If an onsite evaluation is scheduled, that is a good time for the case manager to inform the family that a tour of the unit is also required and a family member should call the Clinical Liaison at the above number to schedule a visit.
- 4) Following the clinical evaluation and acceptance based on the clinical needs, a proposed plan of care is submitted to the funding source for approval (if other than Medicare or Medi-Cal).
- 5) The leadership team of the SAU makes a final decision regarding acceptance after all of the information and assessments are completed. Pertinent portions of the medical record; Results of the onsite clinical evaluation; Family tour information; and Funding information / requirements are all utilized in making the final determination.

This may sound like it takes an excessive amount of time, but it can often be accomplished within 24 hours. That being said, the earlier the referral, the better the outcome with respect to timely transfers.

FAXED REFERRALS SHOULD INCLUDE:

- □ Face sheet with current / complete funding and family contact information
- If Medi-Cal application has been completed, the CIN #
- □ H&P and pertinent consults (Respiratory; Infectious Disease etc.)
- Most recent 3 to 4 days of doctor progress notes
- □ Most recent 3 to 4 days of Nursing notes
- Wound care notes
- Recent Labs
- □ Most recent cultures (urine, sputum, stool etc.)
- Recent chest X-ray
- Isolation needs
- Respiratory notes / O2 levels / vent settings etc.
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