HYPOTHERMIA REFERRAL TO HCAM HOMELESS SERVICES

1. **Today's Date:** _____ 2. **Hospital:** _____

3. **Patient Name:** _____ 4. **DOB:** _____

5. **SSN:** _____ 6. **Phone number:** _____

7. **Mailing Address:** _____

8. **Emergency Contact:** _____ 9. **Phone Number:** _____

10. **Relationship:** _____

11. **Date patient first seen in the ER:** _____

12. **Patient diagnosis(es)**: _____

13. **Patient disposition:** {Note: Circle one}

Still in ER Discharged from ER - date: _____

Admitted to hospital – date: _____ Room No. _____

14. **Where does the patient currently sleep most often?** {NOTE: Circle one}

Own Home/Apartment Family/Friends' Home Shelter

Transitional Housing Treatment/Hospital Jail/Prison

Car/Van Outdoors Subways Hotel/Motel Abandoned Building

Other: _____

15. **Where does the patient usually stay during the day?** _____

16. **This form was completed by:** _____ 17. **Phone/pager:** _____

18. **Notes**: _____
_____

** Please fax this completed form to **410-510-1626** as soon as the patient is identified as Homeless and diagnosed with Cold-Related Injury/Hypothermia. A Homeless Outreach Advocate will contact the patient. Contact Dudley Greer with any questions or concerns at dgreer@hcamaryland.org or 410-949-2580. Thank You. **