Rutland Regional Medical Center
www.RRMC.org | 160 Allen Street, Rutland, VT | 802.775.7111
Healthy You. Healthy Together.

Mendon Mountain View Referral

Date: _____ **Name of guest:** _____**DOB**_____

Guest Phone # _____Does phone have **video capability:** ☐ Yes ☐ No **Email:** _____

Guest's Emergency Contact and phone # _____

Referring agency and contact: _____

Date of onset of symptoms, if known: _____

Current symptoms: _____

Reason why they do not have a place to self-isolate:

☐ Homeless ☐ risks exposure to others in the Home ☐ Congregate living ☐Other_____

Where will they return when they recover? _____

Ability to care for self: ☐ ambulation ☐ taking medications ☐ managing chronic conditions

Estimated date of departure from MMV _____**VNA consent signed?** ☐ Yes ☐ No

Contacted Onsite person date_____ **spoke with** _____ **Time of arrival** _____

Is the patient a smoker? ☐ Yes ☐ No **Guest arriving with NRT** ☐ Yes ☐ No

Is this patient currently on oxygen? ☐ Yes ☐ No **Is the oxygen** ☐ New or ☐ Previous?

Is this patient currently on MAT? ☐ Yes ☐ No

Medications (Patient recommended to arrive with 14 day medication supply)

_____

PCP (who will be responsible for ordering prescriptions while at MMV)

_____

Any safety plans in place that MMV staff should be aware of? ☐ Yes ☐ No _____

Transportation Needs or Arrangements

_____

Meal restrictions or Allergies

_____

_____

Please provide the individuals COVID test results when making this referral