UNIVERSITY of MARYLAND MEDICAL CENTER

LORD BALTIMORE HOTEL
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BALTIMORE CITY HEALTH DEPARTMENT

Lord Baltimore TRI Center (LBTC) - Community Referral Form

**For anyone referring patients from outside LBTC – please refer to pg.4 for instructions*

Date: ______________________________ Time: ______________________________

Resident name: ______________________________ Preferred name: ______________________________

Resident cell phone #: ______________________________ DOB: ______________________________

Primary language: ______________________________ Preferred pronoun: ______________________________

Housing status:

☐ Homeless/unstably housed

☐ Housed but unable to isolate or care for self

☐ Congregate setting (shelter or other group setting – housed with multiple other people

Name of shelter/ congregate living facility: ______________________________

Home address or address of shelter/ congregate living facility: ______________________________

Address for pick-up (if different than above): ______________________________

Referral contact (name and phone number): ______________________________

Referral Source:

☐ ED/Hospital

☐ Shelter

☐ Health Department

☐ Health clinic

☐ Other

☐ Healthcare for the Homeless

☐ Esperanza Center

☐ Recovery/substance use treatment program

☐ Self

Referral form completed by:	
Intake status:	Approved Hold Denied
Referral approved by:	
Most recent test result:	POS NEG PEND
Type of test:	PCR RAPID
Floor placement on arrival:	POS PUI Quarantine
Testing needed on arrival:	YES NO
Information entered into RedCap:	YES
RedCap Encounter #:	#
Transportation needed?	YES NO
Logistics informed?	YES
Room assigned:	

COVID-19 Information:

COVID Test Date and Location: ___________________________________

COVID Test Result: ☐ Positive ☐ Pending ☐ Needs testing (*requires approval by provider*)

Was it a RAPID ANTIGEN TEST or PCR TESTING? ☐ RAPID antigen test ☐ PCR
**If person is unsure, confirm type of test when reviewing results*

Test result confirmed by (TRI Center staff in CRISP or other): ____

Has the patient ever tested positive for Covid before? ☐ **Yes** ☐ **No** If so, when? ________________________________

Is the person symptomatic? ☐ **Yes** ☐ **No** Date symptoms began: ___________________________________

Known close/high-risk exposure? ☐ **Yes** ☐ **No** Date of last exposure: _______________________________

Has this person been a patient in any hospital in the last 48-hours? ☐ **Yes** ☐ **No**

If yes, which hospital? ____

Brief History (COVID history, symptoms, reason TRI Center isolation is required):

____

____

____

Medical Information:

Primary Care Provider: _____________________________________ Pharmacy: _________________________________

Medical and mental health diseases:

____

____

____

Current Medications:

____

____

____

Does the patient have a 10-day supply of all required daily medications? ☐ **Yes** ☐ **No**

Does the patient use any injectable medication (insulin, hormones) and if so, do they also have a 14-day supply of needles? ☐ **Yes** ☐ **No**

Do they have a glucometer if needed? ☐ **Yes** ☐ **No**

Smoker: ☐ **Yes** ☐ **No** Marijuana use: ☐ **Yes** ☐ **No** Medical marijuana card: ☐ **Yes** ☐ **No**
**if yes, MUST bring card to LBTC for verification*

Current alcohol use: ☐ **Yes** ☐ **No**

If yes, number of drinks per day and date/time of last drink: ____

History of withdrawal:____

Illicit opioid use (heroin/fentanyl/pain pills): ☐ **Yes** ☐ **No**

If yes, use per day and date/time of last use: ____

On medication for opioid use disorder? ☐ **Yes** ☐ **No**

If yes, ☐ methadone ☐ buprenorphine (suboxone) Number of doses on hand: ______________

Name and phone number of treatment program: ____

Eligibility Criteria – *Is/has the resident:*

YES	NO	Able to independently perform any activities of daily living (eating, bathing, toileting, dressing, transferring)?
YES	NO	Able to independently manage medications (dosing, storage)?
YES	NO	Able to independently make all their own medical decisions?
All answers above must be 'YES'		
YES	NO	Displayed any mental health conditions that may require monitoring or supervision for their safety (or safety of others), including suicidal ideation?
YES	NO	Displayed any aggressive/violent/threatening behaviors in the last 48-hours?
YES	NO	Bedbound, or restricted to bed/immobilized for any reason (including MSK injuries)?
YES	NO	Had any persistent vomiting or diarrhea, and/or any concerns for C. difficile?
YES	NO	At risk for (or any history of) alcohol or benzodiazepine withdrawal? **If YES - must be discussed further with LBTC provider*
YES	NO	Reported any illicit opioid use and not currently on medication for Opioid Use Disorder? **If YES, must be discussed with LBTC provider*
If 'YES' to any of the above questions, the resident may not be eligible for LBTC and must be reviewed with a provider.		

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Has the patient been diagnosed with any other transmittable respiratory infection (influenza, RSV, TB, etc)?

☐ **Yes** ☐ **No**

If symptomatic, have they been tested the flu? ☐ **Yes** ☐ **No** Result: ______________________

Functional needs (ie. wheelchair, hard of hearing, low vision): ___________________________________

Does the patient use a CPAP machine for OSA (*obstructive sleep apnea*)? ☐ **Yes** ☐ **No**

If yes, do they have a machine to bring to LBTC? ☐ **Yes** ☐ **No**

Dialysis: ☐ **Yes** ☐ **No**

If yes, Dialysis location: _______________________ Dialysis schedule:______________________

Has the dialysis center confirmed they will accept this COVID positive or PUI patient? ☐ **Yes** ☐ **No**

Please be sure any person being referred to LBTC is aware of these guidelines PRIOR TO THEIR ARRIVAL

Things to know about LBTC:

- Private room with private bathroom and television
- Three meals a day and snacks
- Families may reside in the hotel together
- Visitors are not allowed
- Bags will be searched to ensure the safety of all residents and guests
- Daily check-ins from clinical team for symptom checking, vital signs, and over-the-counter medication administration
- Smoking room is available
- Must agree to stay on hotel floor - cannot come and go from the building
- Inability to leave the building to procure items such as food or alcohol
- Personal information will not be shared with other agencies and residents will be protected from authorities while at the hotel
- Residents will be asked to stay until they are healthy and no longer infectious - usually about 10 days
- Staying in the hotel is voluntary. If at any time a resident wants to no longer stay at the hotel, they will be permitted to leave

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For anyone referring patients from outside LBTC:

- Please call 443-984-8915 - 7 days a week from 8AM to 7PM
- If referring a resident from an outside organization, please complete this referral form and fax along with any clinical notes, if available, to 443-529-0875.
- Once the referral has been completed and approved, the TRI Center logistics team will work with the referring organization/person to arrange transport.
- For any community referral taken over-the-phone, this form will be completed by clinical staff as part of the referral process.