

Lord Baltimore TRI Center (LBTC) – Community Based Referral Form

- Please call 410-952-8738 - 7 days a week from 8PM 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.

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 leave the building, but can interact with other residents on their floor
- 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

Date: _____ Time: _____

Resident Name: _____ DOB: _____

Resident cell phone number: _____

Primary language: _____

Referral contact (name and phone number): _____



Referral Source:

- ED/Hospital
- Healthcare for the Homeless
- Shelter
- Esperanza Center
- Health Department
- Recovery/substance use treatment program
- Health clinic
- Self
- Other

Housing Status:

- Homeless/Unstably Housed
- Congregate setting (shelter or other group setting (housed with multiple other people))
- Housed but unable to isolate or care for self

Home address and/or name of shelter/congregate living:

Address for pick up (if different than above):

COVID-19 Information:

COVID Test Date and Location: _____

COVID Test Result: Positive Pending Not yet tested (*requires approval by provider*)

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

PUI or quarantine – Is the person symptomatic and/or have a known close exposure? Yes No

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):

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? <i>*If YES - must be discussed further with LBTC provider</i>
YES	NO	Reported any illicit opioid use and not currently on medication for Opioid Use Disorder? <i>*If YES, must be discussed with LBTC provider</i>
YES	NO	Been diagnosed with any other transmittable respiratory infection (influenza, RSV, TB, etc)
<u>If 'YES' to any of the above questions, the resident may not be eligible for LBTC and must be reviewed with a provider.</u>		



Medical Information:

Primary care provider: _____

Pharmacy: _____

Medical and mental health diagnoses:

Current Medications: _____

DOES THE PATIENT HAVE A 14-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

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)

Name and phone number of treatment program: _____

Number of doses on hand: _____



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

TRI Center Staff: _____ Date: _____ Approved Denied