Discharge Referral Form

IMPORTANT: This form must be fully completed and submitted to Bethel Shelters once a patient is identified as needing services. Please notify the Bethel Shelters Program Director (Brooke Leaverette - bleaverette@bethelshelters.org) as soon as possible, as bed availability is limited. Allow a reasonable time for referrals to be reviewed, as each referral must be staffed before acceptance. Once approved, a confirmation email will be sent with the date and time of the reserved bed. It is strongly recommended that the patient be discharged during weekday business hours (8:30 AM–5:30 PM).

Referrals should only be submitted for individuals who are medically stable and able to independently complete activities of daily living (ADLs). Placement must be confirmed by the shelter prior to discharge.

Client Information

Full Name: _____

Date of Birth: _____

Last Known Address (must be in York, Chester, Lancaster):

_____

Shelter Discharge Planning

Date of Discharge Planning Conversation: _____

Was the client informed and in agreement to discharge to Bethel Shelters?

☐ Yes ☐ No

Brief Notes/Outcome of Discussion:

_____

_____

_____

Revised: 03/24/2026

Medical & Functional Status at Discharge

List of Current Medications:

_____

_____

_____

Activities of Daily Living (ADLs):

Can the client independently complete daily tasks such as bathing, dressing, and eating?

☐ Yes ☐ No

Mobility of Belongings:

Can the client carry or manage their belongings independently?

☐ Yes ☐ No

Ability to Perform Light Chores:

Can the client complete simple tasks (e.g., make their bed, tidy their area)?

☐ Yes ☐ No

Ambulation:

Can the client walk at least one City block (with or without mobility aid)?

☐ Yes ☐ No

Follow-Up

Scheduled appointment with the doctor, along with pharmacy information (if needed).

Where: _____

Date & Time: _____

Anticipated Discharge Date:_____

Pharmacy Information:_____

Prescriptions must be called into a local pharmacy, 29730 or 29732 area code