A Place of Refuge Ministries of South Wisconsin, Inc.

Post Office Box 241524, Milwaukee, Wisconsin 53224
Phone: 414-760-2483
Cell: 262-420-0370
Fax: 414-797-4011
www.aplaceofrefuge.org

INSTRUCTIONS TO THE PHYSICIAN FOR COMPLETION OF THE DOCUMENTS GIVEN TO YOU BY YOUR PATIENT

Your patient, _____, has applied for residency in Refuge House, a group home for pregnant women and their preborn children.

In order for her application to be considered, the following four documents need to be completed by you, her physician.

- Part A: PHYSICIAN EXAMINATION REPORT
- Part B: PREGNANCY STATEMENT
- Part C: PHYSICIAN MEDICAL RELEASE – required to reside in Refuge House
- Part D: RELEASE OF MEDICAL INFORMATION

Refuge House Intake Committee will schedule an interview with the applicant when these four reports are faxed to us at 414-797-4011. Therefore, please fax completed forms as soon as possible.

Thank you for assisting your patient find safe housing that is supportive and nurturing of pregnant women and their preborn children.

"For I was hungry and you gave me food, I was thirsty and you gave me drink, I was a stranger and you welcomed me, I was naked and you clothed me, I was sick and you visited me, I was in prison and you came to me." (Matthew 25:35-36 (ESV))

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Part A: PHYSICIAN EXAMINATION REPORT

Patient (Applicant): _____ Birthdate ____/____/____

Address _____ City, State, Zip _____

General Information:

Height _____ Weight _____ Blood Type_____

Blood Pressure _____Urinalysis_____

Diabetes_____

Dietary Recommendations_____

Hearing _____ Vision _____

Is the patient currently taking any medications/supplements? Yes _____ No _____

If YES, please list medications/supplements with dosage:

Do you have any recommendations for future care, additional tests or examinations and/or immunizations?

Yes _____ No _____ If YES, please explain: _____

Are there any medical conditions Refuge House should be apprised of for the health, safety, and well-being of your patient while participating in our program?_____

_____

Physician Signature _____ Date ____/____/____

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Part B: PHYSICIAN PREGNANCY STATEMENT

I, _____, confirm that my patient, _____
(physician – please print) (patient – please print)
is pregnant. Her estimated due date is _____.

She is expected to deliver at_____ Hospital.

The following tests are required of all applicants to Refuge House:

TB screen: Date test given ____/____/____ Date test read ____/____/____ Results: Positive / Negative

HIV Screen: Date test given ____/____/____ Date test read ____/____/____ Results: Positive / Negative

STI Screen Date test given ____/____/____ Date test read ____/____/____ Results: Positive / Negative
(including Syphilis, Gonorrhea, Herpes)

COVID-19 Date test given ____/____/____ Date test read ____/____/____ Results: Positive / Negative

Drug Screen Date test given ____/____/____ Date test read ____/____/____ Results: Positive / Negative

If positive, please list the substances_____

My patient appears to be free of any communicable diseases. Yes ____ No ____

Physician Signature: _____ Date _____/_____/_____

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Part C: PHYSICIAN MEDICAL RELEASE REQUIRED BY REFUGE HOUSE

This document is to be completed by the physician and signed by both the physician and the applicant for the following reasons:

• Refuge House is a two- story home with all of the resident's bedrooms and bathrooms located on the second floor.

• We do not charge a fee for any services. Rent, utilities, food, personal care products, baby supplies and clothing are provided. However, residents are required to do their own laundry and share household chores, including cooking and cleaning.

Physician: If you are in agreement, please initial each of the items below, adding additional notes in the area provided:

_____ My patient may climb stairs and dine on the first floor with the other house residents.

_____ My patient may ride in the Refuge House van when requiring transportation.

_____ My patient may perform all assigned housekeeping tasks as agreed upon.

_____ My patient may work part-time.

_____ My patient may work full-time.

_____ My patient may go to school.

_____ My patient may participate in moderate exercise.

Physician – Please comment and list all restrictions: _____

_____

_____

Physician Name _____ Office Phone (_____)_____

Physician Signature _____ Date ____/___/_____

Address _____ City, State, Zip _____

Applicant Signature _____ Date ____/___/_____

"For I was hungry and you gave me food, I was thirsty and you gave me drink, I was a stranger and you welcomed me, I was naked and you clothed me, I was sick and you visited me, I was in prison and you came to me." (Matthew 25:35-36 (ESV))

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Part D: PHYSICIAN RELEASE OF MEDICAL INFORMATION

I, _____, hereby authorize my physician, _____
(patient – please print) (physician – please print)
and/or their representatives to release all test results, including HIV, to Refuge House a group living facility. This information will be kept confidential.

Patient Signature: _____ Date _____/_____/_____

Physician Signature: _____ Date _____/_____/_____

"For I was hungry and you gave me food, I was thirsty and you gave me drink, I was a stranger and you welcomed me, I was naked and you clothed me, I was sick and you visited me, I was in prison and you came to me." (Matthew 25:35-36 (ESV))