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Staff Education to Increase Knowledge of Referral Completeness

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College of Nursing

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Tamekia Lindsay Thompson

has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

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Walden University

2026

Executive Summary: Staff Education Project
Staff Education to Increase Knowledge of Referral Completeness

by

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MS, Walden University, 2022

BS, University of the West Indies, 2013

Executive Summary Submitted in Partial Fulfillment
of the Requirements for the Degree of
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Summary

This staff education project addressed a practice gap in a psychiatric facility where nonclinical staff frequently submitted incomplete referral documentation for patients with co-occurring medical and psychiatric conditions. Due to the facility's inability to provide acute medical stabilization, medical clearance is required before nurse practitioners can determine admission appropriateness. The project question was, Does educating intake staff on a standardized referral checklist improve knowledge of referral criteria, as measured by pre- and post-education surveys? The Johns Hopkins evidence-based practice (JHEBP) model informed evidence translation, and the analysis, design/development, implementation, and evaluation (ADDIE) instructional design model underpinned the development and evaluation of the intervention. The literature for the educational project was obtained by searching CINAHL Complete, EBSCO, and ProQuest databases, which resulted in 500 articles; a total of 14 peer-reviewed articles published within the past 5 years were analyzed. Ten admissions staff participated and completed both the pre- and post-surveys via SurveyMonkey. Education was delivered through a 30-min recorded Microsoft Teams session for the day shift and made available to all admissions staff for review. The 78% to 93% change from pretest to the posttest survey represented a 19 percentage point gain in knowledge score that was significant, $t(9) = -5.21, p < .001$. This project supports nursing practice by providing evidence of effective staff education that, if implemented, may improve intake consistency, strengthen interprofessional communication, and promote safer psychiatric admissions.

Background

This Doctor of Nursing Practice (DNP) project addressed a documented practice problem in a standalone psychiatric facility where nonclinical staff reviewed referral documentation for patients with co-occurring medical and psychiatric conditions. Because the facility does not provide acute medical stabilization, complete medical clearance is required before nurse practitioners can determine admission appropriateness. Inconsistent referral completeness contributed to delayed admission decisions, increased administrative burden, and potential patient safety risks. Evidence indicates that incomplete or poorly structured referral documentation in psychiatric intake settings increases variability in clinical decision-making and disrupts admission workflows, particularly for medically complex patients (Berg et al., 2023; Casey et al., 2023; Nymoen et al., 2022; Wilson et al., 2023).

The practice gap targeted by this project was inconsistent knowledge among nonclinical intake staff regarding psychiatric referral requirements. Although admission criteria were available, the absence of a standardized referral checklist and formal staff education resulted in variable application of medical clearance standards. Evidence from research studies, quality improvement initiatives, and expert consensus supports use of standardized referral tools, especially when paired with targeted staff education, to improve documentation completeness, reduce intake variability, and enhance patient safety (Berg et al., 2023; Mesbah et al., 2025). The overall strength of the evidence was rated as good and consistent, supporting translation into practice. Guided by this evidence, I sought to answer the following project problem question: Does educating

admissions staff on a standardized referral checklist improve knowledge of referral completeness as measured by pre- and post-surveys?

Staff Education Project Development

To develop this DNP staff education project, I used the ADDIE instructional design model, in conjunction with the JHEBP model to guide systematic translation of evidence into practice (see Dang et al., 2021). Project development was approved by my Walden University DNP committee, faculty advisor, and practicum preceptor. I followed the structured timeline outlined in the Walden University *DNP Project Process Guide*. Development activities included appraisal and synthesis of peer-reviewed evidence to ensure clinical relevance, validity, and applicability, supporting creation of targeted educational content to address identified staff knowledge gaps and promote consistent application of evidence-based practices within the clinical setting.

Analysis

This staff education project began with identification of a practice gap and development of a focused practice question using the JHEBP question development tool; organizational readiness assessment; strengths, weaknesses, opportunities, and threats (SWOT) analysis; and stakeholder analysis (Dang et al., 2021). The gap involved inconsistent knowledge among nonclinical intake staff regarding medical clearance referral requirements for psychiatric admissions involving patients with medical comorbidities, contributing to incomplete referrals, delayed admission decisions, and repeated clarification prior to psychiatric evaluation.

With assistance from a Walden University librarian, I conducted a literature search in the following databases: CINAHL Complete, EBSCO, and ProQuest. The search was limited to peer-reviewed sources published within the past 5 years. Search terms included *psychiatric admission*, *behavioral health intake*, *medical comorbidity*, *standardized checklist*, and *referral documentation*. Approximately 500 records were identified; after screening and duplicate removal, 14 high-relevance articles were appraised using JHEBP research and nonresearch appraisal tools. The final evidence base included Levels II–V studies, quality improvement initiatives, clinical guidelines, and expert consensus. Evidence strength was rated as good and appropriate for translation into practice. Findings consistently supported the use of standardized referral tools paired with staff education to improve referral completeness, reduce intake variability, and support patient safety without increasing unnecessary testing or inappropriate exclusions (Berg et al., 2023; Casey et al., 2023; Mesbah et al., 2025; Nymoen et al., 2022; Wilson et al., 2023). Education was identified as a key factor influencing adherence to structured referral processes (Grover & Singh, 2022).

Practice site analysis using the JHEBP organizational readiness tool, SWOT analysis, and stakeholder analysis confirmed readiness for change, leadership support, and implementation feasibility. Strengths included experienced clinical leadership and openness to workflow improvement, while gaps included the absence of standardized intake tools and formal referral education. Engagement from intake leadership, nurse practitioners, and medical directors supported sustainability of the proposed intervention.

Design and Development

To operationalize the design and development phases, I used the JHEBP translation and action planning tool (see Dang et al., 2021). Educational materials were developed with the assistance of three content experts, to address knowledge gaps among nonclinical intake staff related to standardized medical clearance requirements for psychiatric admissions involving medically complex patients. The intervention consisted of a PowerPoint educational module (see Appendix A), and a pre- and post-education knowledge survey (see Appendix B) focused on referral completeness, exclusion criteria, and escalation processes. Content selection was grounded in Levels II–V evidence demonstrating that structured referral tools paired with targeted staff education improve intake accuracy, reduce workflow variability, and support patient safety (see Berg et al., 2023; Casey et al., 2023; Mesbah et al., 2025; Nymoer et al., 2022; Wilson et al., 2023).

Three content experts evaluated content validity(see Appendix C), M. A., is a board-certified physician in internal and emergency medicine with over 35 years of experience and supervisory responsibility for referral medical review at the project site, P. F., is a family nurse practitioner with more than 20 years of experience involved in psychiatric referral evaluations, and C. B., is a DNP-prepared family nurse practitioner and PhD candidate with expertise in evidence-based practice and clinical education. All reviewers completed structured evaluations and confirmed that materials were clear, evidence-based, and appropriate for nonclinical intake staff. Feedback was incorporated to refine the standardized psychiatric referral checklist (see Appendix D) to improve clinical clarity and workflow alignment. Prior to implementation, the final materials were

approved by my DNP faculty advisor and committee in accordance with the university's DNP staff education manual.

Implementation

Prior to implementation, I completed the Walden University ethics pledge and obtained approval from my Walden University DNP faculty advisor and practicum site leadership in accordance with the Walden University DNP staff education manual. This project involved staff education only and did not include access to patient records, protected health information, or direct patient interactions. Participation was voluntary, and staff were informed that participation or nonparticipation would not affect employment status or professional standing. Confidentiality was maintained, no personally identifiable information was collected, and completion of the surveys constituted implied consent. To acknowledge participant time, staff who completed both surveys received a \$10 Starbucks coffee card; this was disclosed in advance and not contingent upon responses.

I administered the education virtually to accommodate staffing needs across three shifts so not to disrupt workflow. A 30-min live session was conducted via Microsoft Teams during a scheduled morning meeting, with five admissions team members in attendance. The PowerPoint module was recorded and made available for asynchronous review to ensure access for staff working evening and night shifts. A total of 10 admissions staff completed both the pre- and post-education surveys, including two admissions shift leaders, one admissions assessor, one social worker, and six intake coordinating staff members. Participants accessed the pre-education survey through

SurveyMonkey and were assigned unique numeric identifiers to match pre- and postsurvey responses while maintaining anonymity. The presurvey included 10 knowledge-based items assessing baseline understanding of standardized medical clearance referral requirements. The PowerPoint educational module was viewed on December 11, 2025, at the beginning of the day shift huddle during a 30-min session, after which participants completed the post-education survey containing the same items; all data were collected electronically and used solely for project evaluation.

Evaluation

During the evaluation phase, I assessed changes in admissions staff knowledge following implementation of the standardized referral checklist and educational module. Knowledge was measured using a 10-item questionnaire administered before and after the intervention (see Dang et al., 2021). Descriptive statistics, including item-level frequencies, percentages, and mean knowledge scores, were calculated using Microsoft Excel. Knowledge scores were derived from total correct responses and converted to percentages; demographic variables were not analyzed. Inferential analysis included a paired samples *t* test to examine pre- and postintervention differences, with a Wilcoxon signed-rank test used as a nonparametric confirmation due to the small sample size (see Dang et al., 2021). Instrument reliability was evaluated using the Kuder–Richardson Formula 20, and content validity was established through expert review using the content validity index.

Results

Content Expert Validity Index

Content validity was supported by full expert agreement. All three experts rated the materials as quite relevant or highly relevant using a 4-point relevance scale and affirmed that the content was clinically accurate and appropriate for nonclinical admissions staff. Content validity indices reflected full expert agreement, with an item-level content validity index of 1.00 for all 10 items and a scale-level content validity index average of 1.00, exceeding recommended benchmarks and demonstrating excellent content validity

Pre- and Post-survey Results

Ten participants completed both the pretest and post-test surveys. The 10-item knowledge questionnaire assessed knowledge of standardized medical clearance referral requirements, exclusion criteria, and escalation processes for psychiatric admissions involving medically complex patients. Pretest results reflected moderate baseline knowledge with variability across content areas; items related to general referral awareness and routine documentation were answered correctly by most participants, whereas lower performance was observed on items requiring higher-level judgment, including identification of exclusion-level conditions, response to abnormal vital signs with missing diagnostics, and escalation decisions for complex comorbidities. Following the educational intervention, posttest scores improved across most items, with the greatest gains occurring in areas of initial difficulty, indicating effective targeting of safety-sensitive intake decisions. Mean pretest scores were 7.8 correct responses ($SD =$

0.92; 78.0%), increasing to 9.3 correct responses ($SD = 0.79$; 93.0%) on the posttest, for a mean knowledge gain of 19.0%. Item-level pre- and post-test results are presented in

Table 1

Table 1

Number and Percentage of Correct Responses Before and After the Educational Intervention (N = 10)

Item	Pretest n (%)	Posttest n (%)	% change
1	9 (90)	10 (100)	+10
2	10 (100)	10 (100)	0
3	7 (70)	9 (90)	+20
4	7 (70)	8 (80)	+10
5	9 (90)	10 (100)	+10
6	6 (60)	8 (80)	+20
7	7 (70)	10 (100)	+30
8	7 (70)	10 (100)	+30
9	8 (80)	8 (80)	0
10	8 (80)	10 (100)	+20
<i>M%</i>	78.0	93.0	19.0

Paired t Test

A paired-samples t test showed a significant increase in knowledge scores, $t(9) = -5.21, p < .001$, with a large effect size (Cohen's $d = 1.65$). A Wilcoxon signed-rank test also indicated a significant improvement, $Z = -2.81, p = .005$, with a large effect size ($r = .89$).

Strengths and Limitations

The findings of this staff education project demonstrate that a targeted educational intervention improved admissions staff knowledge related to referral requirements for

patients with co-occurring medical and psychiatric conditions. Improved knowledge has important implications for nursing practice in behavioral health settings, where accurate and timely intake decisions are essential for patient safety (Berg et al., 2023; Casey et al., 2023). Increased understanding of referral completeness, exclusion criteria, and escalation processes may promote more consistent intake practices, reduce delays in psychiatric evaluation, and decrease reliance on nurse practitioners to resolve incomplete referrals. These findings are consistent with evidence indicating that standardized referral tools paired with staff education improve intake accuracy, reduce workflow variability, and support safer psychiatric admission processes for medically complex patients (Berg et al., 2023; Casey et al., 2023; Mesbah et al., 2025; Nymoen et al., 2022; Wilson et al., 2023).

Several limitations should be considered. I conducted the project at a single psychiatric facility with a small sample size and no control group, limiting generalizability. Outcomes were measured using a knowledge-based questionnaire rather than direct measures of referral quality, admission timeliness, or patient outcomes, and posttest scores approached a ceiling effect for some items (see Dang et al., 2021). Despite these limitations, the statistically significant improvement in knowledge supports staff education as a feasible and meaningful practice change. Future project researchers may examine long-term knowledge retention and assess the impact of standardized referral education on referral completeness and admission efficiency.

Conclusions

This DNP staff education project demonstrated that educating non-clinical intake staff on a standardized psychiatric referral checklist improved knowledge of medical clearance requirements for patients with co-occurring medical and psychiatric conditions. The statistically significant improvement in postintervention scores indicates that admissions staff were better prepared to identify incomplete referrals, apply exclusion criteria, and follow appropriate escalation pathways prior to nurse practitioner review. These gains support safer psychiatric admission processes and more consistent intake decision-making.

From an organizational perspective, improved intake knowledge may reduce admission delays, strengthen communication between referral sources and intake teams, and support more efficient use of clinical resources. More broadly, standardizing intake practices supports equitable access to timely psychiatric care for medically complex patients by reducing variability that may disproportionately affect vulnerable populations (Berg et al., 2023; Casey et al., 2023; Mesbah et al., 2025; Wilson et al., 2023). By strengthening admissions staff knowledge through evidence-based education, this project supports improved quality, patient safety, and positive social change within behavioral health systems.

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Appendix A: Staff Education PowerPoint Module

IMPROVING REFERRAL COMPLETENESS WITH THE STANDARDIZED CHECKLIST

Presented by
Tamekia Lindsay Thompson
DNP Student Candidate



Learning Objectives

By the end of this session, staff will be able to:

1. Explain why referral completeness is critical in a standalone psychiatric facility (≥ 2 reasons in discussion).
2. Identify ≥ 4 exclusion criteria and ≥ 3 clearance triggers ($\geq 90\%$ accuracy in case drill).
3. Apply the checklist using Yes/No/N/A and request missing info (skills drill).
4. Communicate with referral sites using the standard script (role-play).





Why This Matters

Improving Referral Completeness With a Standardized Checklist

- Why completeness matters
- Ensuring safe psychiatric admissions
- Streamlining communication
- Supporting NP decision-making

(Wilson et al., 2023; Casey et al., 2023)



Impact of Incomplete Referrals


1. Patients: unsafe or delayed admissions (Wilson et al., 2023)

2. Employees: repeated calls, lost time (Ebnehoseini et al., 2022)

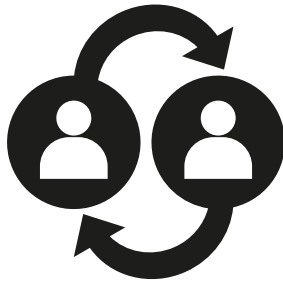
3. Facility: strained partner relationships, credibility risk (Musuuza et al., 2024)



Benefits of a standardized Checklist

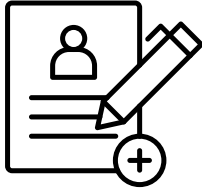
- Standardizes workflow across staff (Festini et al., 2024)
- Builds referral-site trust (Musuuza et al., 2024)
- Supports NP decisions with complete packets (Casey et al., 2023)
- Creates a record of due diligence (Ebnehoseini et al., 2022) 

The Referral Workflow



- Collect chart from referral site
- Complete checklist
- If incomplete → request missing info
- If exclusion → Do Not Admit
- If complete → forward to NP (Casey et al., 2023;

Wilson et al., 2023) 



Vital Signs & Stability

- HR <55 or >110 → update reading + EKG → Flag NP (Thrasher et al., 2019)
- BP <100 systolic / >180 systolic / >100 diastolic → update reading → Flag NP (Thrasher et al., 2019)
- SpO₂ <92% → confirm O₂ use; document L/min (Berg et al., 2023)
- Include 24-hr trends when available (Berg et al., 2023)



Do Not Admit Criteria

- Stage III–IV or draining wound needing complex care
- Active GI bleed
- Active TB needing IV antibiotics/isolation
- Hospice/terminal care
- Tracheostomy/ventilator, central lines, continuous IV meds, PEG pump feeds
- Unstable seizures, bowel obstruction, acute head trauma, unstable/open fractures (Grover & Singh, 2022; Wilson et al., 2023)





Clearance Triggers

- BAL ≥ 300 → require medical clearance prior to NP review (Thrasher et al., 2019)
- Chest pain, acute confusion, overdose <24 hrs → stability/clearance documentation (Casey et al., 2023)
- Pregnancy → maternal/fetal status + gestational age (Wilson et al., 2023)
- Insulin pump → self-management plan / receiving-unit capability (Wilson et al., 2023)
- Physical therapy needs → documentation of frequency, complexity, and diagnosis required (Festini et al., 2024)



Checklist in Action

- Proceed top-to-bottom: Vitals → Wounds → Conditions → Devices → Triggers
→ Diabetes → Labs → Docs
- Answer Yes/No/N/A
- If No → request immediately
- If Exclusion → Do Not Admit
- If Flag → forward to NP (Festini et al., 2024; Ebnehoseini et al., 2022)



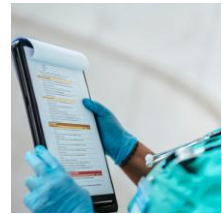
Communicating with Referral Sites



"Hello, this is [Name] from [Hospital]. We reviewed the referral for [Patient, DOB]. Before NP review, we need [specific missing items —e.g., updated vitals, wound staging, OB documentation]. Could you send that now so we can complete the checklist and move forward?"



Case Scenario 1



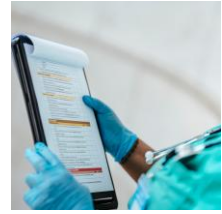
Case: HR 120; BP 110/70; SpO₂ 96% (room air). Stage III pressure ulcer documented.

Questions:

- How do you document this on the checklist?
- What is the disposition and communication to the site?



Case Scenario 2



Case: Depression, diabetes; BP 185/102; glucose logs included; patient pregnant but no OB note.

Questions:

- What do you request?
- When do you forward to NP?



Thank You!



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Appendix B: Pre- and Post-survey Questionnaire

Q1. Referral completeness carries greater risk in a standalone psychiatric hospital compared to a general hospital for which of the following reasons? *(Select all that apply)*

- A. Incomplete packets increase NP liability for unsafe admissions
- B. The hospital cannot provide extensive acute medical stabilization
- C. Missing information can delay psychiatric treatment decisions
- D. The facility is legally required to admit all referrals regardless of stability

Q2. Which set of missing items would most likely cause unsafe admission risk rather than workflow inconvenience?

- A. Missing insurance information, emergency contact details, or MAR signatures
- B. Missing wound staging, oxygen requirements, or recent vital signs
- C. Missing psychiatric diagnosis summary, treatment goals, or patient signature
- D. Missing allergy list, pharmacy preference, or primary care provider note

Q3. Which of the following are considered Exclusion (Do Not Admit) conditions? *(Select all that apply)*

- A. Patient on central line with active infusion
- B. Patient with PEG tube on pump feeds
- C. Patient with stable seizure disorder managed by neurology
- D. Patient with EF 30% and history of heart failure
- E. Patient with Stage II wound requiring daily dressing changes

Q4. A referral shows: HR 118, BP 112/76, SpO₂ 91% on room air. No EKG is included. What should admissions staff do first?

- A. Accept the patient because blood pressure is stable
- B. Flag for NP immediately without requesting updates

- C. Request updated vitals, oxygen documentation, and an EKG
- D. Exclude due to low oxygen saturation

Q5. Which of the following is a clearance trigger rather than an exclusion?

- A. Patient on ventilator support with tracheostomy
- B. Patient with BAL of 325 mg/dL and no ED clearance note
- C. Patient in hospice care with end-stage dementia
- D. Patient with unstable open fracture awaiting reduction

Q6. A patient is referred with: Diabetes, stable vitals, complete med list, but no glucose values for the past 24 hrs. What is the appropriate action?

- A. Forward packet to NP since vitals are stable
- B. Exclude since glucose logs are mandatory for all diabetics
- C. Request glucose documentation before NP review
- D. Flag as incomplete but forward anyway for NP to decide

Q7. Which responsibilities belong specifically to admissions staff in the referral workflow? (*Select all that apply*)

- A. Gathering charts from referral partners
- B. Completing the checklist and marking Yes/No/N/A
- C. Requesting missing or incomplete documentation
- D. Making final clinical admission decisions
- E. Forwarding only complete or flagged packets to NP

Q8. Which communication reflects the professional tone expected with referral sites?

- A. "We cannot move forward until you provide a wound stage and updated vitals; please fax them immediately."
- B. "We reviewed [Patient's] referral. Before NP review, we need updated glucose logs and an EKG. Can you send those so we can complete the checklist?"

- C. “Your referral is incomplete again. Please stop sending patients without the required documents.”
- D. “This case should be fine, but send whatever you have when convenient.”

Q9. A patient referred with heart failure, EF 30%, stable vitals, and full documentation is under review. What is the correct action?

- A. Accept since the vitals are stable and well-documented
- B. Exclude due to EF <35% as it exceeds facility criteria
- C. Flag for NP review and request additional cardiology notes
- D. Accept only if physical therapy notes are attached

Q10. During referral review, labs show potassium 2.9 mmol/L and sodium 121 mmol/L. No documentation of treatment is included. What should admissions staff do?

- A. Forward immediately to NP since psychiatric symptoms are the priority
- B. Exclude the patient due to abnormal labs regardless of other factors
- C. Request documentation of treatment and repeat labs, then flag for NP
- D. Accept the referral if all psychiatric documentation is otherwise complete

Answer Key

Q1. A, B, C

Q2. B

Q3. A, B, D

Q4. C

Q5. B

Q6. C

Q7. B, C, E

Q8. B

Q9. B

Q10. C

Appendix C: Content Validity Index (CVI) Tool

Instructions for Expert Reviewers

Please rate each item on the 10-item knowledge questionnaire using the following scale:

Item #	Survey Item	1	2	3	4
Q1	Referral completeness carries greater risk in a standalone psychiatric hospital compared to a general hospital for which of the following reasons?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q2	Which set of missing items would most likely cause unsafe admission risk rather than workflow inconvenience?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q3	Which of the following are considered Exclusion (Do Not Admit) conditions?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q4	A referral shows: HR 118, BP 112/76, SpO ₂ 91% on room air. No EKG is included. What should admissions staff do first?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q5	Which of the following is a clearance trigger rather than an exclusion?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q6	A patient is referred with diabetes, stable vitals, complete med list, but no glucose values for the past 24 hrs. What is the appropriate action?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q7	Which responsibilities belong specifically to admissions staff in the referral workflow?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q8	Which communication reflects the professional tone expected with referral sites?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q9	A patient with heart failure, EF 30%, stable vitals, and full documentation is under review. What is the correct action?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q10	During referral review, labs show potassium 2.9 mmol/L and sodium 121 mmol/L. No documentation of treatment is included. What should admissions staff do?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

1 = Not relevant

2 = Somewhat relevant

3 = Quite relevant

4 = Highly relevant

Appendix D: Referral Checklist

A. Vital Signs & Trends

- Vitals documented in last 24 hrs: Yes / No / N/A
- Trending vitals (past 24 hrs) available: Yes / No / N/A
- HR <55 or >110? Yes / No / N/A → If Yes → Request updated reading + EKG → Flag for NP
- BP <100 systolic OR >180 systolic OR >100 diastolic? Yes / No / N/A → If Yes → Request updated reading → Flag for NP
- SpO₂ <92%? Yes / No / N/A → If Yes → On oxygen? Y / N → If Y: ____ L/min documented? Y / N

B. Wounds

- Any wound present: Yes / No / N/A
- If wound present → Stage documented: Yes / No / N/A
- Stage III–IV wound OR draining wound needing complex care: Yes / No / N/A → If Yes → Exclude

C. Medical Conditions

- Hypertension diagnosis: Yes / No / N/A → If Yes → Stable BP/HR documented? Y / N
- Heart failure diagnosis: Yes / No / N/A → If Yes → EF documented? Y / N → Request / Flag
- Active GI bleed / uncontrolled bleeding: Yes / No / N/A → If Yes → Exclude
- Active TB / infectious disease needing IV antibiotics or isolation: Yes / No / N/A → If Yes → Exclude
- Cancer diagnosis: Yes / No / N/A → If Yes → Treatment status (active chemo/radiation vs remission) documented? Y / N → Request / Flag
- Seizure disorder: Yes / No / N/A → If unstable → Exclude
- Bowel obstruction requiring treatment: Yes / No / N/A → If Yes → Exclude
- Acute head trauma / TBI without psychiatric illness: Yes / No / N/A → If Yes → Exclude
- Unstable/open fractures or joint dislocation (until reduced): Yes / No / N/A → If Yes → Exclude
- Recent surgery/procedure (<30 days): Yes / No / N/A → If Yes → Notes included? Y / N
- Specialist consulted: Yes / No / N/A → Notes included? Y / N
- Physical therapy required: Yes / No / N/A → If Yes → Complexity, frequency & diagnosis documented? Y / N → Request / Flag

- On anticoagulation: Yes / No / N/A → If Yes → On warfarin? Y → Flag for NP
- Hospice / terminal care: Yes / No / N/A → If Yes → Exclude

D. Devices & Supports

- Tracheostomy / ventilator dependence: Yes / No / N/A → If Yes → Exclude
- Central line in use (PICC, Port, Hickman): Yes / No / N/A → If Yes → Exclude
- Continuous IV medications/fluids: Yes / No / N/A → If Yes → Exclude
- PEG tube feeds (pump feeds): Yes / No / N/A → If Yes → Exclude
- PEG tube (gravity feeds): Yes / No / N/A → Care plan included? Y / N → Flag for NP
- Foley catheter present: Yes / No / N/A → If Yes → Flag for NP

E. Clearance Triggers

- BAL ≥ 300 : Yes / No / N/A → If Yes → Clearance included? Y / N → Request → Flag
- Chest pain: Yes / No / N/A → If Yes → Clearance included? Y / N → Request → Flag
- Acute confusion: Yes / No / N/A → If Yes → Clearance included? Y / N → Request → Flag
- Overdose within last 24 hrs: Yes / No / N/A → If Yes → Clearance included? Y / N → Request → Flag
- Pregnancy: Yes / No / N/A → If Yes → OB/fetal status + gestational age documented? Y / N → Request → Flag
- Insulin pump: Yes / No / N/A → If Yes → Self-management/plan documented? Y / N → Request → Flag
- Physical therapy needs: Yes / No / N/A → If Yes → Complexity, frequency & associated diagnosis documented? Y / N → Request → Flag

F. Diabetes & Nutrition

- Diabetes diagnosis: Yes / No / N/A
- Glucose values (past 24 hrs) documented: Yes / No / N/A
- Eating status documented: Yes / No / N/A
- Diet specifications included: Yes / No / N/A

G. Labs & Interventions

- Any abnormal labs present? Yes / No / N/A → If Yes → Results included? Y / N
- Was treatment/intervention given? Yes / No / N/A
- Were repeat labs completed after treatment? Yes / No / N/A → Results included? Y / N

H. Required Documentation Pack

- Med list / MAR: Yes / No / N/A
- Allergies / infection alerts: Yes / No / N/A
- Wound care notes: Yes / No / N/A

- Specialist notes: Yes / No / N/A
- Surgery/procedure notes: Yes / No / N/A
- EKG (if HR <55 or >110, or cardiac history): Yes / No / N/A

Disposition

- Complete → Forward to NP for final approval/denial
- Incomplete → Sent back to referral site for missing info
- Exclusion present → Do Not Admit
- Trigger/uncertain → Forward to NP for decision