Department of Veterans Affairs

REFERRAL FOR COMMUNITY NURSING HOME CARE

VETERAN'S NAME	IDENTIFICATION NUMBER

DATE OF BIRTH	SEX ☐ MALE ☐ FEMALE	MARITAL STATUS	RELIGIOUS PREFERENCE

NAME, ADDRESS AND TELEPHONE NO. OF NEAREST RELATIVE	NAME AND ADDRESS OF NURSING HOME SELECTED
NAME AND ADDRESS OF REFERRING VA HOSPITAL	NAME AND ADDRESS OF FOLLOW-UP HOSPITAL

PLANNED DATE OF ADMISSION	ESTIMATED DURATION OF STAY	BED TENTATIVELY RESERVED ☐ YES ☐ NO	BY WHOM?	MODE OF TRAVEL REQUIRED

TITLE AND TELEPHONE NO. OF VA OFFICIAL TO BE CONTACTED IN CASE OF AN EMERGENCY

IF VETERAN IS INCOMPETENT TO HANDLE FUNDS, CHECK APPROPRIATE BLOCK

☐ RATED BY VA ☐ ACTION PENDING *(Explain)*

☐ ADJUDGED BY COURT

I concur in the selection of the above-named community nursing home and authorize the release of necessary medical information from hospital records to the nursing home

SIGNATURE OF VETERAN *(or person acting for the veteran) (This signature should be secured whenever possible, but it is not mandatory.)*	DATE SIGNED

MEDICAL INFORMATION

MAJOR DIAGNOSES *(Attach a copy of VA Form 10-1000)*	DOES PATIENT KNOW DIAGNOSIS? ☐ YES ☐ NO

CHECK ANY OF THE FOLLOWING IF THEY ARE PRESENT

DISABILITIES	IMPAIRMENTS	MILD	MOD.	SEV.	ACTIVITY TOLERANCE LIMITATIONS
☐ AMPUTATION	☐ SPEECH	☐	☐	☐	
☐ PARALYSIS	☐ HEARING	☐	☐	☐	☐ NONE
☐ CONTRACTURE	☐ VISION	☐	☐	☐	☐ MODERATE
☐ DECUB. ULCER	☐ SENSATION	☐	☐	☐	☐ SEVERE
☐	☐ TREMORS	☐	☐	☐	☐

TEST	DATE	RESULTS
CHEST X-RAY		
C.B.C		
SEROLOGY		
URINALYSIS		

OTHER IMPORTANT MEDICAL INFORMATION *(Include allergies, if any)*

PHYSICIAN'S RECOMMENDATIONS *(Include prognosis, medications, treatment, physical therapy, etc.)*

SIGNATURE OF PHYSICIAN	DATE

SOCIAL INFORMATION

PATIENT	ACCEPTANCE OF ILLNESS/DISABILITY ☐ GOOD ☐ FAIR ☐ POOR ☐ N/A	UNDERSTANDS THE REASON FOR NURSING HOME PLACEMENT ☐ YES ☐ PARTLY ☐ N/A	PARTICIPATED IN PLANNING ☐ YES ☐ NO ☐ N/A
	INTERESTED IN THE FOLLOWING ACTIVITIES		
FAMILY	PARTICIPATED IN PLANNING ☐ YES ☐ NO ☐ N/A	ACCEPTED NURSING HOME PLAN ☐ YES ☐ RELUCTANTLY ☐ NO ☐ N/A	EXPECTED TO VISIT ☐ YES ☐ NO ☐ N/A
OTHER	VA VOLUNTEER WILL VISIT PATIENT ☐ YES ☐ NO	FREQUENCY OF VISITS	RECOMMEND USE OF NON-VA VOLUNTEERS ☐ YES ☐ NO

STATUS OF PLANS FOR CARE AFTER VA AUTHORIZATION TERMINATED: *(Comment)*	NAME OF SOCIAL WORKER ACTIVE IN PLANNING PLACEMENT
☐ UNDERWAY ☐ COMPLETED ☐ NOT STARTED	

NURSING CARE PLAN (Suggestions for active care)

BED: Position in good body alignment and change position every _____ hrs.
Avoid _____ position.
Prone position _____ times/day as tolerated.
SIT IN CHAIR _____ hrs. _____ times/day.

WEIGHT BEARING: ☐ Full ☐ Partial ☐ None on _____ leg.

SOCIAL ACTIVITIES:
Encourage group _____ Individual _____
within home _____
outside home _____

EXERCISES: Range of motion _____ _____ times/day.
to _____
by ☐ Patient ☐ Nurse ☐ Family
Stand _____ Min. _____ times/day.
Other:

SELF-CARE STATUS

Check level of ability. Write "S" in space if needs supervison only.		INDE-PENDENT	NEEDS ASSIST-ANCE	UNABLE TO DO
BED ACTIVITY	TURNS			
	SITS			
PERSONAL HYGIENE	BATHING			
	FACE, HAIR, ARMS			
	TRUNK & PERINEUM			
	LOWER EXTREMITIES			
	SHAVING			
	ORAL HYGIENE			
	BLADDER PROGRAM			
	BOWEL PROGRAM			
DRESSING	UPPER EXTREMITIES			
	TRUNK			
	LOWER EXTREMITIES			
	APPLIANCES, SPLINT			
FEEDING				
LOCO-MOTION	SITTING			
	STANDING			
	WHEELCHAIR			
	WALKING			
	STAIRS			

COMMUNICATION ABILITY	YES	NO	PARTLY
CAN SPEAK			
CAN WRITE			
UNDERSTANDS SPEAKING			
UNDERSTANDS GESTURES			
UNDERSTANDS WRITING			
UNDERSTANDS ENGLISH			
(If "No", what language)			

MENTAL ALERTNESS	
ALERT	
FORGETFUL	
CONFUSED	
OCCASION. CONFUSED	
ADJUSTMENT	
SOCIABLE	
WITHDRAWN	
SENILE	

APPLIANCES	HAS	USES	NEEDS
EYEGLASSES			
DENTURES			
HEARING AID			
PROSTHESIS			
CRUTCHES			
CANE			
WHEELCHAIR			
OTHER *(Specify)*			

BED

LOW BED: ☐ YES ☐ NO
SIDE RAILS: ☐ YES ☐ NO
MATTRESS: ☐ REGULAR ☐ FIRM
OTHER:

REMARKS

NOTES BY HOSPITAL NURSE *(Include observations, instructions given patient/family regarding illness, treatment taught, etc.)*

DATE
SIGNATURE OF NURSE
TITLE OF NURSE

PATIENT'S DIET
☐ REGULAR ☐ MODIFIED *(Specify type)*

FOOD LIKES AND DISLIKES AND/OR CULTURAL FOOD HABITS

DATE
SIGNATURE OF DIETICIAN

RECOMMENDED LEVEL OF CARE
☐ SKILLED NURSING FACILITY ☐ INTERMEDIATE CARE FACILITY

PLEASE INITIAL:

PHYSICIAN	SOCIAL WKR	NURSE

REMARKS AND OTHER PERTINENT INFORMATION

ACTION BY HOSPITAL CHIEF OF STAFF
☐ APPROVED ☐ DISAPPROVED

SIGNATURE

DATE SIGNED