Patient Name: _____ Last 4 #SS_____

VAMC COATESVILLE
Inpatient Preadmission Referral- Telephone No. 610-384-7711

Mon – Fri 8am-3:30pm CVAMC Geriatrics and Extended Care: ext 5119 Fax No. 610-466-2260	3:30pm-8am Mon – Fri, weekends/holidays CVAMC Urgent Care Area: ext: 4290 Fax no. 610-466-2210

Name of Referring Professional Completing this form: _____**Phone:**_____
Patient's Name: _____Age: _____ Desired Date of Admission: _____
Full SS#: _____ Date of Birth_____ Phone: _____
Home Address: _____

FOR WHAT CATEGORY & TREATING SPECIALTY IS THE VET BEING REFERRED TO THE CLC? :

TS Codes CIRCLE EACH NEED	**Service Categories**
	SHORT-STAY CATEGORIES: please provide narrative on the baseline and needs to achieve stated treatment goals.
47	*Short-Stay* Respite Care
64	*Short-Stay* Rehabilitation a. PT: _____Please provide baseline functioning & current needs: _____ b. OT: _____ Please provide baseline functioning & current needs: _____ c. ST: _____Please provide baseline functioning & current needs: _____
66	*Short-Stay* Restorative Care ID services needed:_____ _____
67	*Short-Stay* Continuing Care Reason:_____
68	*Short-Stay* Mental Health Recovery Services needed:_____ _____
69	*Short-Stay* Dementia Care Services needed:_____ _____
81	*Short-Stay* Geriatric Evaluation and Management (GEM) : _____
95	*Short-Stay* Skilled Nursing Care ID skilled need:_____
96	*Short-Stay* Hospice and Palliative Care: _____
CIRCLE	***LONG-STAY CATEGORIES:***
42	*Long-Stay* Dementia Care Services needed: _____
44	*Long-Stay* Continuing Care Services needed:_____
45	*Long-Stay* Mental Health Recovery Services needed:_____
46	*Long-Stay* Spinal Cord Injury and Disorders Services needed:_____

WHAT IS THE EXPECTED LENGTH OF STAY? _____

Patient Name: _____ Last 4 #SS_____

TO WHERE WILL THE VETERAN BE DISCHARGED? _____

PLEASE DESCRIBE WITH WHOM & HOW YOU CONFIRMED THE ABOVE AS BEING A SAFE & REALISTIC DISCHARGE PLAN UPON THE ACHIEVEMENT OF TREATMENT GOALS WITHIN YOUR EXPECTED LENGTH OF STAY:

_____
_____
_____
_____

Primary Diagnosis(es) _____

Patient Records that MUST BE SUBMITTED with this referral:	√
A copy of all PROGRESS NOTES since date of admission	
A copy of most recent HISTORY AND PHYSICAL	
A copy of Active Inpatient/Outpatient MEDICATION List:	
A copy of IMAGING REPORTS:	
A copy of LAB RESULTS:	

RECENT MEDICAL SURGICAL COURSE/Medical Diagnosis(es):

_____

Question:	YES	NO	COMMENTS:
Current hx of MRSA/VRE or other infectious diseases?			
STABLE for Transfer?			
Copy of ADV Directive &/or DNR sent with patient?			
Patient/family notified & CONSENT to TRANSFER?			

What is the patient's **PREFERRED LANGUAGE** WHEN DISCUSSING **HEALTHCARE?** _____

PLEASE DESCRIBE ANY IMPAIRMENTS/BARRIERS TO COMMUNICATION:

VISION?_____ COGNITION? _____
HEARING? _____ LANGUAGE? _____
SPEECH? _____ WRITING? _____

Does the patient/family use **ASSISTIVE DEVICES** to **COMMUNICATE**?_____
Please describe **CULTURAL ASPECTS** that affect COMMUNICATION/CARE: _____
_____
How are any/all listed impairments/barriers to communication **addressed presently**? _____
_____

Decision-making:

( ) Yes ( ) No Capacity to make health care decisions
Physician making the determination: _____Date_____
( ) Yes ( ) No Advance Health Care Directives
( ) Yes ( ) No POA Financial: Name_____
( ) Yes ( ) No POA Health Care: Name_____
( ) Yes ( ) No Guardianship (of person/of estate): Name_____

Next of Kin: Name: _____ Relationship:_____ Phone:_____

Patient Name: _____ Last 4 #SS_____

***PLEASE** provide **CONTACT INFORMATION of EMOTIONAL SUPPORT PERSON** if other than persons listed above: _____

DISCHARGE PLAN–Anticipated Care Needs When Patient Reaches Baseline-☑ all that apply:

____Home alone
____Home with family caregiver
____Home with home care services
____Adult home or other congregate setting
____Assisted Living
____Nursing Home
____Substance abuse rehabilitation
____Other, **Explain**_____

***Has the patient/family been educated about the discharge options/plans? ___YES ___ NO**

***Has the patient/family stated agreement with the plan** to apply at Coatesville VA? ____ If **yes**, please provide date of documentation and provide copy of documentation with this form. If **no**, please state their preferred placement facility? _____

Financial/Insurance Information:

( ) Medicare: Part A _____ ( ) Medicare: Part B _____
( ) SSA: $_____ ( ) SSD: $_____ ( ) Medicaid #: _____
( ) Third Party Insurance Carrier: _____
Policy Number: _____Phone #: _____
Address: _____
( ) Financial guardian/Payee: [provide name/address/phone#] _____
_____

****Please** provide **name, title, and contact information** for party responsible for arranging care options and/or return transfer to your facility after this patient's care is complete with Coatesville VAMC:
_____

CARE CONSIDERATIONS

Ht._____ Wt._____ ALLERGIES: _____

Current **MEDICATIONS**/dose (include over the counter) **LIST** attached? YES or NO - If no, please list here:
_____
_____

If veteran is DIABETIC, most recent Blood Sugar. _____ date_____
Most recent BP: _____ and Temperature _____ date & time_____

Does the patient have DIALYSIS needs? Type:_____ Access site:_____ Facility/Schedule:_____

Does the patient have any TUBES (IVs/feeding/drainage/airway/etc)? Type/purpose: _____

Does the patient have any WOUNDS, SPECIAL CARE/TREATMENTS: _____

Will the patient require any SPECIALTY CONSULTS?_____

RECENT CONSULTS done: _____Results (PLEASE ATTACH DOCUMENTS):_____

Are any **medical appointments pending**? No _____ Yes _____date? _____ Details: _____

Patient Name: _____ Last 4 #SS_____

>>>>>>>***COMPLETE ADL SCORE BELOW:*** *Enter score & comments to describe* ***ADL/IADL functional status****:*

Basic ADLs **Instrumental ADLs**

Score patient in each category with a **"0" for INDEPENDENCE** or a **"1" for DEPENDENCE** & provide add'l details on **function** or **risks** in **"COMMENTs"** column. Total score should equal no more than 7 or 8. DO NOT SKIP ANY ACTIVITY.

ACTIVITY	SCORE	COMMENTS		ACTIVITY	SCORE	COMMENTS
BATHING				TELEPHONE		
AMBULATE				SHOPPING		
DRESSING				FOOD PREP		
TOILETING				HSEKEEPING		
TRANSFERS				LAUNDRY		
CONTINENT				TRANSPORT		
FEEDING				MEDS		
				FINANCES		
TOTAL SCORE				TOTAL SCORE		

*******FALL RISK ASSESSMENT*******:

Any FALLS over the past 90 days? Yes____ No____ Please explain: _____

Was an injury sustained as a result of the fall(s)? Yes____ No ____ Type of injury:_____

Current Gait Stable? Yes ____ No ____ Describe GAIT/FALL RISK issue: _____

RECOMMENDATIONS for addressing fall risk: _____

_____

BEHAVIOR ISSUES:

a. ( ) Yes ( ) No Physically threatening. How has this been managed?
Explain: _____
_____

b. ( ) Yes ( ) No Verbally threatening. How has this been managed?
Explain: _____
_____

c. ( ) Yes ( ) No Is patient currently in restraints or sedated?
Explain_____
_____

d. ( ) Yes ( ) No Required restraint/sedation since hospitalization due to disruptive behavior. How has this been managed?
Explain: _____
_____

e. ( ) Yes ( ) No Does the patient present with other behavior management problems?
Explain: _____
_____

f. ( ) Yes ( ) No Is the patient non-compliant with medication and/or treatment recommendations and/or provisions of financial information/cooperation ?
Explain: _____

g. Oriented to: Time___ Place___ Person___

Patient Name: _____ Last 4 #SS_____

Circle all that apply: Does patient exhibit? wandering tendencies… … resistance to care… ….dementia….
...intrusiveness… …withdrawn… …verbal abuse… …physical aggression… delirium…. sexually inappropriateness

* **If seen by psychiatrist, PLEASE ATTACH copies of all psychiatrist notes and evaluation.**

History of ETOH/Substance Abuse:_____ Current use:_____
Physical/Chemical restraints used in the last 7 days?(describe)_____
If veteran has SEIZURES, are they linked to ETOH withdrawal? ___Yes _____ last seizure date; ___ No/None
Is the veteran a smoker? _____

Does veteran receive **regular medical care**? ___ (Provider/Contact info:_____)

Who brought patient to hospital? ( ) Ambulance; ( ) Family; ( ) Self; ( ) Other - Explain:_____

Residence prior to current hospitalization:
Housing:
( ) Rented room ( ) Boarding House ( ) Apartment ( ) Homeless-Explain:_____
( ) House ( ) Domiciliary ( ) Homeless Shelter _____
( ) Board & Care ( ) Assisted Living ( ) Nursing Home _____
Lives with:
( ) Alone ( ) Spouse ( ) Children ( ) Other relative ( ) Significant other ( ) Non- relative

***LACK of consistent home environment – **Explain: _____**

Psychosocial Circumstances:

a. Does the patient depend upon a frail, elderly or disabled caregiver for his/her care?
Explain: _____
_____

b. Is the patient unsafe in his/her current living environment?
Explain_____
_____

c. Does patient exhibit signs or symptoms of abuse, neglect or mistreatment?
Explain: _____
_____

d. Upon completion of treatment, will the patient return to his/her current residence?
Explain: _____
_____

e. Does the patient abuse ETOH or other substances and is in need of treatment services?
Explain: _____

f. How were patient's needs being met in the community prior to hospitalization?
Explain: _____

Check all that apply regarding patient's care prior to hospitalization

____ Patient received Meals on Wheel
____ Patient was totally self care
____ Family provided care giving services
____ Patient lived in congregate care setting
____ Patient received services from paid caregiver
____ Patient attended Adult Day Care Program

Patient Name: _____ Last 4 #SS_____

DEPARTMENT OF VETERANS AFFAIRS
Medical Center
1400 Blackhorse Hill Road - 115
Coatesville, PA 19320

In Reply Refer To: 542/115

STATEMENT OF UNDERSTANDING

The Veteran listed below has requested admission to the Community Living Center (CLC). It is important that the Veteran understands the following:

- The CLC treatment team includes the Veteran in establishing goals starting on the day of admission.
- These goals always aspire to the Veteran's highest level of functioning and independence; and, therefore, always include discharge planning.
- Continuing stay in the CLC is based on progress toward these goals.
- When goals are met or progress cannot be made, then the treatment team finalizes discharge planning.
- The treatment team will recommend a discharge plan to appropriately meet the Veteran's needs.
- Veterans who are subject to copays when admitted to the Community Living Center (CLC), may be responsible for fees as high as $97.00 per day. Please note that the Veteran or responsible person must agree to be responsible for paying applicable copays in order to be eligible to receive Extended Care Services. An estimate of projected copays will be provided prior to admission.

Name of Veteran_____

I,_____verify by my signature that I have received and
Veteran or Next-of-Kin
understand the information listed above and agree to cooperate with timely discharge planning and payment of applicable copayments.

_____ _____
Signature of Veteran or Next-of-Kin Date

_____ _____
Signature of Witness Date