Geriatrics & Extended Care Pre-Admission Respite Request Form

Respite Days Used since January of current year ____ Date Sent to VET_____

Desired Admission Date_____ **Desired Discharge Date**_____

Veteran's Name _____SS #_____-____-_____
Location of veteran _____ Allergies _____
DOB_____AGE_____ Ht _____ Wt _____ Service Connected %_____

Name of Person Making Request: _____

Relationship to the VET: _____Phone _____ FAX_____

Primary Caregiver's name & contact_____

_____

Please provide the **Vet's emotional support person's name/contact** info if different than above: _____ Relationship _____

Reason Veteran cannot be left alone and caregiver is in need of respite: _____
Health Problems _____

_____

Please list any **NEW** Conditions the Vet has _____
Are any specialty consults needed on this veteran while he is here?_____

Where does the Vet live now? _____Who cares for the vet?_____

When the respite stay is complete will Vet return to same place and caregiver? __Yes

If no, please explain _____

Please list ALL information below about ALL Medications:

Prescribed or Over-the-counter	Dose	How many times a day	Route given (rectally/feeding tube/oral)	Other info

Primary Care Doctor's name _____

Phone_____FAX:_____ Date last seen_____ For What?_____

Does the Vet see any **NON-VA doctors** for care? If Yes please provide:

Doctor's name _____Phone_____FAX:_____

Date last seen_____ For What? _____

HAVE YOU CALLED Vet's **NON-VA doctor's office to request current medical records** be faxed to our Admissions Office: 610-466-2260?__yes ____date requested; __no

Does the vet have any **contagious diseases**, present or past? _____

Does the vet require **Dialysis**? ___no ___yes - dialysis schedule _____

Please provide Dialysis facility name and phone: _____

Is the Vet currently receiving/using any special **Medical Treatments/Equipment**?

Wound/bedsore treatments_____ Oxygen _____

Urinary catheter _____ Tube Feedings_____ Colostomy _____

IVs_____ Special walking aides_____ Special mattress _____

Other treatments or equipment needed _____

Mental Status:

Does the Vet know who the people around him are? _____

Can the Vet tell you where he/she is in any given location? _____

Can the Vet tell you the current month, day, year, time of day, season?_____

Is the Vet confused? _____ Does he/she have the mental capacity to make decisions for him/herself? _____

Does the Vet have an **Advance Directive** _____ or a Do Not Resuscitate Order_____ ?

Does the Vet have a Legal Guardian, Medical Power of Attorney, Financial Power of Attorney, **Durable Power of Attorney**? If yes, please submit copies of legal documentation with this request. Is caregiver assistance needed with above? _____

Please provide the name of **Vet's CVAMC social worker** _____

BASIC ACTIVITIES OF DAILY LIVING:

Please indicate if the Vet needs help with any of the activities below and what kind of help in a couple of words. (Example: Dressing: Yes, needs help w buttons)

HELP NEEDED?	YES	NO	Explain:		Help needed?	yes	no	Explain:
BATHING					TELEPHONE			
AMBULATE					SHOPPING			
DRESSING					FOOD PREP			
TOILETING					Housekeeping			
TRANSFERS					LAUNDRY			
CONTINENT					TRANSPORT			
FEEDING					MEDS			
TYPE OF Diet					FINANCES			

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

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

Was any injury sustained as a result of the fall(s)? Yes____ No ____ Describe injury ____
_____

Is Vet at risk for FALLS? Yes ____ No____; Describe GAIT/FALL RISK _____
_____

RECOMMENDATIONS for addressing FALL RISK _____
_____

Does the Vet exhibit any of the following behaviors? (Circle all that apply:)

wanders resistive to care intrusive withdrawn verbal abuse
aggression dementia delirium sexually inappropriate

Has Vet been restrained Physically or with medications in past 7 days? _____

Does the vet consume alcohol or recreational drugs? _____

Does the vet have a history of drug or alcohol abuse? _____

Is the Vet a Smoker? _____

Can the Vet **Communicate** his/her Needs?_____

PLEASE describe any **impairments/barriers to Communication**:

Vision? _____ Cognition? _____

Hearing? _____ Language? _____

Speech? _____ Writing? _____

Does the Vet use **Assistive Devices to Communicate**? _____

Please describe **Cultural Aspects** that may affect **Vet's Care/Communication**: _____

_____

What is the vet's **PREFERRED LANGUAGE** when discussing **Healthcare**? _____

Will the Vet require the following services: PT_____ OT_____ Speech _____

Does the vet have sleep issues? _____

How do you help vet sleep at home? _____

Any other information you feel is important in caring for your loved one?_____

_____

_____

What does the veteran like to do for fun? _____

_____

Please provide Next-Of-Kin Information:

Name_____Relationship_____Phone#_____

**Person completing this form please, print and sign your name below with date form was provided to VA:*

Print Your Name _____Date_____

Sign Your Name _____Date_____

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