COATESVILLE VAMC SATU PREADMISSION INFORMATION

To be completed by referring facility. Fax completed form to:
CVAMC Admissions Office (11Adm)
1400 Blackhorse Hill Road
Coatesville, PA 19320
Telephone No. 610-384-7711, ext 3640/3641
Fax No. 610-466-2268

Please note: This application must be completed (printed) and signed, in its entirety, by a healthcare professional. The turn around time for processing and review of this application, upon receipt, is 7 business days. Please provide your contact information to expedite processing.

Patient's Name_____ **SS#**_____

Home Address _____ **DOB**_____

_____ **Phone** _____

Date of Referral _____

Desired Date of Admission _____

Active Duty Soldier: Yes _____ No _____ Authorization #_____
If Yes, please indicate the name and contact number of Approving Official/Commanding Officer:

_____ _____
Name Telephone #

Referring Provider _____ Phone _____

Referring Facility _____

Reason/motivation for seeking treatment_____

_____

Desired Admission Date_____

Social: Current living arrangements _____

Does Veteran live in an environment that is conducive to recovery? Yes No

Does Veteran have social supports? If yes, specify,

_____

Drug/Alcohol History (please make sure this section is complete and includes abuse of prescription drugs)

Include substance, when began, amount, frequency, route and last use/duration:

(1)_____

(2)_____

(3)_____

(4)_____

List factors impeding outpatient treatment. Ex. Travel distance.

_____

Has Veteran been unable to remain abstinent in an unsupervised setting?

_____

Legal History & Issues:

Is Veteran on probation or parole? Yes / No

Details_____

If yes, is Parole Officer in agreement with treatment at Coatesville VA? (Referral source must speak with PO or have written confirmation) _____

Are charges pending, warrants/unpaid tickets/fines/PFAs or court dates pending? Yes / No

Details_____

_____

Medical Diagnosis(es):

_____

_____

_____

_____

If Veteran has diabetes, most recent blood sugar _____date_____

If Veteran has hypertension, most recent b /p _____date_____

If Veteran has seizures, are they linked to alcohol withdrawal? Yes / No

If Yes, date of last withdrawal associated seizure _____

Current medications and dose for physical problems (including over the counter):

_____

_____

_____

Does Veteran have any scheduled appointments or medical procedures pending? Please list:

_____

_____

_____

Does Veteran receive regular medical care? (If yes, where? By whom?)

_____

Females: Currently pregnant or any possibility of pregnancy?_____
Date of last menstral period_____

If Veteran is responsible for minor children, who will care for them while Veteran is in treatment?

_____

Psychiatric Diagnosis(es):

_____

_____

_____

Suicidal thoughts? No / Yes, describe

_____

_____

Current plan? No / Yes, describe

_____

_____

Suicidal attempts (date/methods):

_____

_____

_____

Homicidal thoughts? No / Yes, describe

_____

_____

History of violence? No / Yes, describe

_____

_____

A/V hallucinations? No / Yes, describe

_____

_____

Psychiatric medications/dose:

_____

_____

Is Veteran able to self-medicate? Yes / No

Does Veteran use a pill box? Yes / No Does someone else fill box for Veteran? Yes / No

Whom? _____

Is Veteran independent with all ADL's? Yes / No

Is Veteran able to ambulate without assistance? Yes / No If No, what device is used?

_____

Planned disposition upon completion of SATU program _____

Please attach any additional information that will assist in the admission review process. Thank you.

_____ _____ _____

Name and Title of Person completing this form | Business Telephone/Extension | Date

_____

Signature