



1. Source of Referral		2. Living Situation	
This referral is being made from? (Check one)		2.1 With whom does the patient live? (Check one)	2.2 Where does the patient live? (Check one)
1.1 Outpatient Clinic	<input type="checkbox"/>	2.1.1 Alone	<input type="checkbox"/>
1.2 Hospital < 7 days	<input type="checkbox"/>	2.1.2 Spouse only	<input type="checkbox"/>
1.3 Hospital > 6 days	<input type="checkbox"/>	2.1.3 Spouse with others	<input type="checkbox"/>
1.4 VA Nursing Home	<input type="checkbox"/>	2.1.4 Child (not spouse)	<input type="checkbox"/>
1.5 Community Nursing Home	<input type="checkbox"/>	2.1.5 Others (not spouse or children)	<input type="checkbox"/>
1.6 VA Domiciliary	<input type="checkbox"/>	2.1.6 Group setting with non-relatives	<input type="checkbox"/>
1.7 HBPC	<input type="checkbox"/>	2.1.7 Other (Specify)	<input type="checkbox"/>
1.8 Other (Specify)	<input type="checkbox"/>		

3. Primary Caregiver Information		6. Instrumental Activities of Daily Living	
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<b>Primary (unpaid) Caregiver</b> The person (unpaid) who provides most support for patient, need not be a relative. Do NOT include any paid caregivers here	3.1 No caregiver Check no caregiver only if there is no one on whom the patient relies on for any type of support. Do not check if there is ANY person who provides ANY type of support		In the last 7 days, has the patient expressed <b>difficulty</b> with the following activities? <i>Consider how difficult it is or would have been for the patient to perform these IADL activities on his/her own in the last seven days. If you have not seen the patient perform these tasks, you must use your judgment.</i>		Last 7 Days YES    NO			
	3.2 Last name	3.3 First name						
	3.4 Street Address		6.1 Preparing Meals (planning, cooking, setting out food and utensils) Answer YES if patient does NOT prepare meals, even if s/he could.					
	3.5 City	3.6 State	3.7 ZIP	6.1.1 Were meals prepared by others?				
	3.8 Telephone number with area code		6.2 Housework (e.g., dishes, dusting, laundry)					
	3.9 Caregiver's relationship to patient? (Check one) Spouse <input type="checkbox"/> Child or child-in-law <input type="checkbox"/> Other relative <input type="checkbox"/> Friend/neighbor <input type="checkbox"/>		6.3 Shopping (selecting items, managing money)					
	3.10 Support provided by informal caregiver (Check all that apply) Advice/emotional support <input type="checkbox"/> ADL help <input type="checkbox"/> IADL help <input type="checkbox"/>		6.4 Transportation (getting to places beyond walking distance-any mode)					
	3.11 Caregiver lives with patient?		YES <input type="radio"/>	NO <input type="radio"/>	6.5 Using the phone (receiving or making calls - may use assistive devices)			
	3.12 Caregiver accessible to patient? Lives close enough to see pt. and provide care regularly.		YES <input type="radio"/>	NO <input type="radio"/>	6.6 Managing medications (remembering to take meds, refill meds, opening bottles, correct dosages, etc)			
	3.13 Caregiver willing/able to increase help? Ask caregiver if s/he is willing, use your own judgment about his/her ability to increase help. Code NO if the caregiver is unwilling or, if in your judgment, is unable.		YES <input type="radio"/>	NO <input type="radio"/>	6.7 Managing own finances (maintaining a checkbook, paying own routine bills, etc.)			

4. Language (Check any language the patient speaks and understands)		7. Services in the Home <i>Code NO if patient has been in hospital, nursing home or out of the home for the time period of the question.</i>	
4.1 English <input type="checkbox"/>	Spanish <input type="checkbox"/>	Other (specify)	
		7.1 In the last 14 days, has the patient received assistance from a home health aide in the home?	
		7.2 In the last 14 days, has the patient received assistance from a social worker in the home?	
		7.3 In the last 30 days has the patient received help in the home from an RN? OR is an RN scheduled or authorized to make home visits in the next 30 days?	

5. Homebound Status	
5.1 Is the patient homebound (able to leave the home only infrequently and for short periods of time)?	YES <input type="radio"/> NO <input type="radio"/>

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8. Additional Information		YES	NO	
8.1 In the last <b>90</b> days, has the patient moved in with others or have others moved in with the patient?		<input type="radio"/>	<input type="radio"/>	
8.2 Are there any hazards or other factors that make it difficult for the patient to enter or leave the home? Any environmental factor e.g., environmental factors such as stairs, broken elevators, etc., that make it difficult to leave the home (do not count poor lighting or loose rugs/carpet)		<input type="radio"/>	<input type="radio"/>	
8.3 Does the patient or primary caregiver believe the patient would be better off in another living environment?		<input type="radio"/>	<input type="radio"/>	
8.4 In the last 7 days, did the patient engage in 2 or more hours of physical activity, e.g., walking, cleaning the house or exercising?	<input type="radio"/>	<b>YES</b> , Performed for <b>2</b> or more hours		
	<input type="radio"/>	<b>NO</b> , not performed or less than <b>2</b> hours		
8.5 In the last 7 days, has the patient been left alone in the mornings or afternoons?	<input type="radio"/>	<b>YES</b> , Occasionally alone, even if only for an hour		
	<input type="radio"/>	<b>NO</b> , Never or hardly ever		
8.6 Does the veteran have a substitute (surrogate) decision-maker designated? (Check any that apply, include names when available)				
<input type="checkbox"/> Guardian <input style="width: 150px;" type="text"/>		Durable Power of Attorney <input type="checkbox"/> Health Care <input style="width: 150px;" type="text"/>		
<input type="checkbox"/> Fiduciary/Conservator <input style="width: 150px;" type="text"/>		<input type="checkbox"/> Financial <input style="width: 150px;" type="text"/>		
8.7 Has the patient completed an Advance Directive? YES <input type="radio"/> NO <input type="radio"/> (If yes, please place copy in Medical Record or send with patient)				
9. Skilled Care		10. Basic Activities of Daily Living		
Will the patient require these treatments after referral?		<i>Code YES if the patient had ANY difficulty, required cueing or supervision, or DID NOT do the task in the last 7 days</i>		
YES				
9.1 CPAP/BiPap or Ventilator	<input type="checkbox"/>	In the last 7 days, has the patient required <b>help OR supervision</b> to perform any of the following activities?	Last 7 Days	
9.2 Oxygen	<input type="checkbox"/>		YES	NO
9.3 Suctioning	<input type="checkbox"/>	10.1 Bathing (tub bath, shower, or sponge)	<input type="radio"/>	<input type="radio"/>
9.4 Tracheostomy Care	<input type="checkbox"/>	10.1.1 Did the patient require physical assistance with bathing?	<input type="radio"/>	<input type="radio"/>
9.5 Ostomy Care (other than tracheostomy)	<input type="checkbox"/>	10.2 Dressing (lower and upper body)	<input type="radio"/>	<input type="radio"/>
9.6 Dysphagia Diet	<input type="checkbox"/>	10.3 Eating (taking in food by any method, including tube feedings)	<input type="radio"/>	<input type="radio"/>
9.7 Tube Feeding (any method)	<input type="checkbox"/>	10.4 Using the toilet (using toilet, urinal, bedpan-getting on and off, cleaning self, managing devices used and adjusting clothes)	<input type="radio"/>	<input type="radio"/>
9.8 Parenteral Feeding	<input type="checkbox"/>	10.5 Moving around in bed (moving to and from lying position, turning side to side, repositioning)	<input type="radio"/>	<input type="radio"/>
9.9 IV Infusions	<input type="checkbox"/>	10.6 Transfers (moving to/from bed, chair, wheelchair, standing)	<input type="radio"/>	<input type="radio"/>
9.10 Medications by Injection	<input type="checkbox"/>	10.7 Moving around indoors (Answer yes even if with cane, walker, or scooter - Answer NO if uses wheelchair OR did not get around)	<input type="radio"/>	<input type="radio"/>
9.11 Urinary Catheter Care	<input type="checkbox"/>	10.8 If uses wheelchair, moving around chair (propelling and maneuvering) <i>Code YES if the patient can maneuver wheelchair by him/herself (even if it is a power chair)</i>	<input type="radio"/>	<input type="radio"/>
9.12 Dialysis - Center- based	<input type="checkbox"/>	10.9 Do any of the answers above (10-1 - 10-7) indicate a recent (2-3 mos) change in functioning? <i>Code yes if the patient's function has significantly changed in the recent past</i>	YES	NO
9.13 Dialysis - Home -based	<input type="checkbox"/>		<input type="radio"/>	<input type="radio"/>
9.14 Wound Care (other than pressure ulcer)	<input type="checkbox"/>	<b>11. CONTINENCE</b>		
9.15 Pressure Ulcer Care	<input type="checkbox"/>	11.1 Is the patient incontinent of urine?	<input type="radio"/>	<input type="radio"/>
9.16 Check the stage of the <b>worst</b> pressure ulcer 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/>		11.2 Is the patient incontinent of stool?	<input type="radio"/>	<input type="radio"/>
9.17 Frequent Nurse Observation (more than 1/week)	<input type="checkbox"/>	<b>12. SKIN</b>		
9.18 Physical, Speech, Occupational or Kinesiotherapy	<input type="checkbox"/>	12.1 Has the patient experienced any troubling skin problems like burns, bruises, or itching in the last 30 days?	<input type="radio"/>	<input type="radio"/>
9.19 Alcohol, Drug, or other substance abuse treatment	<input type="checkbox"/>	Additional comments pertinent to this page have been added <input style="width: 200px;" type="text"/>		
9.20 Other (specify) <input style="width: 150px;" type="text"/>				

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### 13. Patient Behaviors and Symptoms

In the last 7 days, has the patient exhibited any of the following?	Last 7 Days	
	YES	NO
13.1 Wandering (moved with no rational purpose, seemingly oblivious to needs or safety)? <i>Wandering is purposeless movement often without regard to safety. Pacing up and down is NOT wandering.</i>	<input type="radio"/>	<input type="radio"/>
13.2 Verbally abusive behaviors (threatened, screamed at, or cursed at others)? <i>Code if any such behavior occurred, regardless of patient's intent.</i>	<input type="radio"/>	<input type="radio"/>
13.3 Physically abusive behaviors (hit, shoved, scratched or sexually abused others)? <i>Code if any such behavior occurred, regardless of patient's intent.</i>	<input type="radio"/>	<input type="radio"/>
13.4 Resisting care (resisted taking medications /injections, ADL assistance, eating, or changes in position)?	<input type="radio"/>	<input type="radio"/>
13.5 Hallucinations or delusions? <i>Hallucinations are <b>sensory</b> (auditory, visual, olfactory, tactile) experiences that are NOT real. Delusions are <b>ideas or beliefs</b> that are held even though there is no evidence to support them or evidence that shows them to be false.</i>	<input type="radio"/>	<input type="radio"/>

### 14. Cognitive Status

14.1 In the last 7 days was the patient able, <b>without difficulty</b> , to make decisions that are reasonable about organizing the day, such as when to get up, what meals to have or what clothes to wear?	<input type="radio"/>	YES, Patient consistently made reasonable decisions <b>without difficulty</b>
	<input type="radio"/>	NO, Patient made decisions <b>with difficulty</b> OR did not make decisions OR decisions were poor
14.2 In the last 7 days, has the patient usually been able to make him/herself understood?	<input type="radio"/>	YES, Patient's expression of information is understood, even if s/he has difficulty in finding words or finishing thoughts
	<input type="radio"/>	NO, Patient's expression of information is never (or rarely) understood OR s/he is limited to making concrete requests
14.3 In the last 90 days has the person become so agitated or disoriented that his safety was endangered or s/he required protection by others as a result?	YES <input type="radio"/>	NO <input type="radio"/>

### 15. Prognosis

15.1 In the last 7 days, has the person experienced a flare up of a recurrent or chronic health problem?	YES <input type="radio"/>	NO <input type="radio"/>
15.2 Does the direct care staff (MD, rehab therapist) think the patient is capable of increased independence (in ADLs, IADLs, or mobility)?	YES <input type="radio"/>	NO <input type="radio"/>
15.3 Does the patient have a limited life expectancy (likely to be less than 6 months)?	YES <input type="radio"/>	NO <input type="radio"/>

### 16. Weight Bearing

16.1 What is the patient's weight bearing status? Full  Partial  None

### 17. Diet

17.1 Diet Regular  Modified (Specify diet)

### 18. What equipment does the patient need? (Please place prosthetics requests)

18.1 Hospital Bed	<input type="checkbox"/>	18.3 Trapeze	<input type="checkbox"/>	18.5 Cane	<input type="checkbox"/>	18.7 ADL equipment	<input type="checkbox"/>	18.9 Other (specify)
18.2 Special mattress	<input type="checkbox"/>	18.4 Walker	<input type="checkbox"/>	18.6 Wheelchair	<input type="checkbox"/>	18.8 Orthotic or splint	<input type="checkbox"/>	<input style="width: 100%;" type="text"/>

### 19. What supplies does the patient need? (Please place orders for supplies)

19.1 Catheters	<input type="checkbox"/>	19.3 Dressings	<input type="checkbox"/>	19.5 Tape	<input type="checkbox"/>	19.7 Ostomy supplies	<input type="checkbox"/>	19.9 Other (specify)
19.2 Tubing	<input type="checkbox"/>	19.4 Wrappings	<input type="checkbox"/>	19.6 Glucose strips	<input type="checkbox"/>	19.8 Saline	<input type="checkbox"/>	<input style="width: 100%;" type="text"/>

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<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>

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20. Goals of Care (check all that apply)		21. Referring to which program? (Check all that apply)			
20.1 Rehabilitation (improved function)	<input type="checkbox"/>	21.1 Skilled care in home	<input type="checkbox"/>	21.10 Long-term nursing home care	<input type="checkbox"/>
20.2 Skilled nursing care (e.g., manage wounds, medical devices, catheters, ostomy)	<input type="checkbox"/>	21.2 Home Based Primary Care (HBPC)	<input type="checkbox"/>	21.11 Outpatient Respite care	<input type="checkbox"/>
20.3 Monitoring/supervision to avoid clinical complications	<input type="checkbox"/>	21.3 ADL assistance (personal care) in home	<input type="checkbox"/>	21.12 Inpatient Respite care	<input type="checkbox"/>
20.4 Improve compliance with medications/treatments	<input type="checkbox"/>	21.4 Chore Services (homemaker) in home	<input type="checkbox"/>	21.13 Specialized Dementia or Geropsych Care	<input type="checkbox"/>
20.5 Patient/Family Education	<input type="checkbox"/>	21.5 Adult Day Health Care	<input type="checkbox"/>	21.14 Inpatient palliative/hospice care (in NHCU )	<input type="checkbox"/>
20.6 Respite (temporary relief for caregiver)	<input type="checkbox"/>	21.6 Residential care (supervised living)	<input type="checkbox"/>	21.15 Outpatient Palliative/ hospice care (in home)	<input type="checkbox"/>
20.7 Palliative/End of Life Care	<input type="checkbox"/>	21.7 Assisted Living	<input type="checkbox"/>	21.16 All inclusive care or PACE program	<input type="checkbox"/>
20.8 Reduce hospitalizations and/or ER visits	<input type="checkbox"/>	21.8 Domiciliary care	<input type="checkbox"/>	21.17 Other (specify)	
20.9 Supervised/supportive living situation	<input type="checkbox"/>	21.9 Short-term nursing home care (subacute care, rehab, etc)	<input type="checkbox"/>		
20.10 Behavior Stabilization	<input type="checkbox"/>				

### 22. Estimated Duration of Care

22.1 1 week   
 22.2 2-3 weeks   
 22.3 One month   
 22.4 2-3 months   
 22.5 4-6 months   
 22.6 Indefinite

**Comments.** (Any additional information that may be helpful to the referral program)

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This Section for Administrative Use Only Use This Section Referral is processing (Check all that apply)

23. Where was the patient referred?

Home Care	Funding Sources for Home Care	Structured Living Situation	Funding Sources for Structured Living Situation
Community Skilled Home Health Care <input type="checkbox"/>	VA <input type="checkbox"/>	Personal Care Home <input type="checkbox"/>	VA <input type="checkbox"/>
VA Home-Based Primary Care <input type="checkbox"/>	Medicare <input type="checkbox"/>	Community Residential Care <input type="checkbox"/>	Medicare <input type="checkbox"/>
Homemaker/Home Health Aide <input type="checkbox"/>	Medicaid <input type="checkbox"/>	Assisted Living <input type="checkbox"/>	Medicaid <input type="checkbox"/>
VA Bowel and Bladder <input type="checkbox"/>	Other insurance <input type="checkbox"/>		Other insurance <input type="checkbox"/>
Adult Day Health Care <input type="checkbox"/>	Private Pay <input type="checkbox"/>		Private Pay <input type="checkbox"/>
VA In-home Respite <input type="checkbox"/>	Other (specify) <input type="text"/>		Other (specify) <input type="text"/>
Domiciliary	Funding Sources for Domiciliary	Nursing Home Care	Funding Sources for Nursing Home Care
VA Domiciliary <input type="checkbox"/>	VA <input type="checkbox"/>	VA NHCU (Rehab) <input type="checkbox"/>	VA <input type="checkbox"/>
State Home Domiciliary <input type="checkbox"/>	Medicare <input type="checkbox"/>	VA NHCU (Long-term care) <input type="checkbox"/>	Medicare <input type="checkbox"/>
	Medicaid <input type="checkbox"/>	VA NHCU (subacute care) <input type="checkbox"/>	Medicaid <input type="checkbox"/>
	Other insurance <input type="checkbox"/>	VA NHCU (respite) <input type="checkbox"/>	Other insurance <input type="checkbox"/>
	Private Pay <input type="checkbox"/>	Community nursing home <input type="checkbox"/>	Private Pay <input type="checkbox"/>
	Other (specify) <input type="text"/>	State Veterans nursing home <input type="checkbox"/>	Other (specify) <input type="text"/>
		VA NHCU (Hospice) <input type="checkbox"/>	
Hospice Care	Funding Sources for Hospice Care	Geriatric Services	Funding Sources for Geriatric Services
VA NHCU (Hospice) <input type="checkbox"/>	VA <input type="checkbox"/>	GEM Clinic <input type="checkbox"/>	VA <input type="checkbox"/>
VA Outpatient hospice <input type="checkbox"/>	Medicare <input type="checkbox"/>	Geriatric Primary Care Clinics <input type="checkbox"/>	Medicare <input type="checkbox"/>
Community hospice <input type="checkbox"/>	Medicaid <input type="checkbox"/>	VA GEM inpatient unit <input type="checkbox"/>	Medicaid <input type="checkbox"/>
	Other insurance <input type="checkbox"/>		Other insurance <input type="checkbox"/>
	Private Pay <input type="checkbox"/>		Private Pay <input type="checkbox"/>
	Other (specify) <input type="text"/>		Other (specify) <input type="text"/>
Care Coordination/Home Telehealth	Funding Sources for Care Coordination/Home Telehealth	OTHER (specify)	Funding Sources for Other Services
Care Coordination/Home Telehealth <input type="checkbox"/>	VA <input type="checkbox"/>	<input type="text"/>	VA <input type="checkbox"/>
	Medicare <input type="checkbox"/>	<input type="text"/>	Medicare <input type="checkbox"/>
	Medicaid <input type="checkbox"/>	<input type="text"/>	Medicaid <input type="checkbox"/>
	Other insurance <input type="checkbox"/>	<input type="text"/>	Other insurance <input type="checkbox"/>
	Private Pay <input type="checkbox"/>	<input type="text"/>	Private Pay <input type="checkbox"/>
	Other (specify) <input type="text"/>	<input type="text"/>	Other (specify) <input type="text"/>
		<input type="text"/>	

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