Hawthorne Veteran and Family Resource Center

Recuperative Care Program Referral Form

250 N. Ash Street

Escondido, CA 92027

Referring party:____ Date of Referral:______/______/_______

Contact number: (_____)_______-__________

Last admission:_______/______/_______

Facility/Unit: ___________________________ __________________________________

Date recuperative bed needed:______/______/_______

ICD-10 Diagnosis:

____

____

____

DEMOGRAPHIC DATA

Name: ____

Gender:

Male ☐ Female ☐ Transgender ☐ Prefer not to say ☐

DOB:_______/______/_______

Age: _______________

Marital Status:

Married ☐ Never Married ☐ Divorced ☐ Committed Relationship ☐ Other: _____________________

Address: ____

____

____

H Phone: (_____)_______-__________ W Phone: (_____)_______-__________

Race: ______________________________________

Ethnicity: ___________________________________

Religious Preference: ____________________________________

Next of Kin:_______________________________________Phone: (______)_______-__________

Relationship: ____

FINANCIAL DATA

Monthly Income: __________________________

Source (s) of Income:

____

VA Service Connected Disability % (if applicable): ____

Payee/ Conservatorship/ Fiduciary:

Yes ☐ No ☐

Explain:

____

____

____

EMPLOYMENT

Currently employed: ____

Work History: ____

Employment Goals: ____

LIVING ARRANGEMENTS: **Homeless:** Yes No

____

____

____

____

SOCIAL SUPPORTS:

MEDICAL AND TREATMENT ISSUES:

ACTIVE PROBLEM(S):

Ongoing medical issues and follow-up treatment:

Home health needs:

Special accommodations:

____

____

Assistive devices:

____

____

____

____

____

Inpatient Unit Information:

Unit name: ____

Contact name: ____

Contact number: (_____)_______-__________

PRIMARY CARE PROVIDER:

Name: ____

Number: (_____)_______-__________

Location: ____

SPECIALTY CARE PROVIDER:

Name: ____

Specialty: ____

Number: (_____)_______-__________

Location: ____

TB CLEARANCE (TB test within 1yr and/or chest x-ray within last 3 mo.):

Yes ☐

No ☐

Explain**:** ____

Medications:

Name of Medication	Strength and Frequency	Condition Medication Taken For	Physician who Prescribed Med	Notes

Allergies

Cause	Reaction

Is Veteran Incontinent?

Yes ☐ No ☐

Explain:

___

___

Is Veteran independent in ADLs:

Yes ☐ No ☐

Explain:

____

____

Veteran uses public transportation:

Yes ☐ No ☐

Veteran self-administers medications:

Yes ☐ No ☐

Explain:

____

____

____

Strengths:

____

____

____

Weaknesses:

____

____

____

SUBSTANCE ABUSE AND TREATMENT HISTORY: (use, last consumption, quantity)

Does Veteran have a problematic use of substances: Yes No

Substance	**First Use**	**Pattern of Use**	**Date/Amount of last use**
Nicotine			
Alcohol			
Cannabis			
Cocaine			
Amphetamines			
Opioids			

Substance Treatment history:

____

____

____

Willing to attend treatment now? Yes ☐ No ☐ Maybe ☐

Explain:

____

Mental Status Exam

OBSERVATIONS					
Appearance	□ Neat	□ Disheveled	□ Inappropriate	□ Bizarre	□ Other
Speech	□ Normal	□ Tangential	□ Pressured	□ Impoverished	□ Other
Eye Contact	□ Normal	□ Intense	□ Avoidant	□ Other	
Motor Activity	□ Normal	□ Restless	□ Tics	□ Slowed	□ Other
Affect	□ Full	□ Constricted	□ Flat	□ Labile	□ Other
Comments:					

MOOD						
□ Euthymic	□ Anxious	□ Angry	□ Depressed	□ Euphoric	□ Irritable	□ Other
Comments:						

COGNITION					
Orientation Impairment	□ None	□ Place	□ Object	□ Person	□ Time
Memory Impairment	□ None	□ Short-Term	□ Long-Term	□ Other	
Attention	□ Normal	□ Distracted	□ Other		
Comments:					

PERCEPTION				
Hallucinations	□ None	□ Auditory	□ Visual	□ Other
Other	□ None	□ Derealization	□ Depersonalization	
Comments:				

THOUGHTS					
Suicidality	□ None	□ Ideation	□ Plan	□ Intent	□ Self-Harm
Homicidality	□ None	□ Aggressive	□ Intent	□ Plan	

Delusions	□ None □ Grandiose □ Paranoid □ Religious □ Other
Comments:	
BEHAVIOR	
□ Cooperative □ Guarded □ Hyperactive □ Agitated □ Paranoid □ Stereotyped □ Aggressive □ Bizarre □ Withdrawn □ Other	
Comments:	
INSIGHT	□ Good □ Fair □ Poor Comments:
JUDGMENT	□ Good □ Fair □ Poor Comments:

PSYCHIATRIC ISSUES AND TREATMENT HISTORY:

Mental health diagnosis: ____

Mental health treatment history: ____

Therapy History: ____

Psychiatric Hospitalization(s):

____

____

____

Suicide History:

Family History: ____

____

____

____

____

Attempts (give detailed information i.e. date, means, plan, circumstance):

____

____

____

____

History of Aggression:

____

____

____

Safety Risk Factors:

____
____
____
____

Mental Health Treatment Provider:

Name: _____________________________________

Number: (_____)_______-__________

LEGAL ISSUES:

Current legal issues: ____

Past legal issues: ____

Warrants: ____

STABILIZATION NEEDS:

____
____
____
____
____
____

Referrals provided:

____
____
____
____
____

Ensure VA Release of Information (s) have been signed and faxed to VA Liaison at *858-404-8371* for referral to Interfaith Community Services Recuperative Care Program.