Recuperative Care Program Referral Form

Referring party: ____

Contact number: ____

Date recuperative bed needed: _______________________

Diagnosis : ____

DEMOGRAPHIC DATA

Name: ____

Gender: _____

Last 4 SSN _____________DOB: ___________________ Age: ______

Marital Status: _________

Address: ____

Phone: ____

Service Connected %: ________

Next of Kin: ____

Phone: ___________________________ Relationship: _____________________________

FINANCIAL DATA

Monthly Income: $ __________

Source of Income: ____

Benefits applied for/status: ____

EMPLOYMENT:

Currently employed: ____

Work History: ____

Employment Goals: ____

Education: ____

Military History:

Branch: ____________________ Years____________________ Combat_______________

Job: ___________________________ Highest Rank: _________ Discharge:_______________

LIVING ARRANGEMENTS: ____

Periods of Homelessness ____

Place of Birth: ________________________

Marital Status: ______

Children: ____

SOCIAL SUPPORTS: ____

MEDICAL AND TREATMENT ISSUES:

____

____

____

ACTIVE PROBLEM(S):

Ongoing medical issues and follow-up treatment: ____

____

Home health needs: ____

Special accommodations: ____

Ambulation device(s):

____

PRIMARY CARE PROVIDER:

Name: ____

Number: ____

Location: ____

SPECIALTY CARE PROVIDER:

Name: ____

Specialty: ____

Number: ____

Location: ____

TB CLEARANCE: ____

CURRENT LEVEL OF FUNCTIONING:

Veteran in independent in ADLs: ________

Veteran uses public transportation: ______

Veteran self-administers medications: ________

Strengths: ____

Weaknesses: ____

SUBSTANCE ABUSE AND TREATMENT HISTORY:

Cigarettes: _________________________ Usage_____________________________________

Alcohol: ____________________________Usage_____________________________________

Cannabis: ___________________________Usage_____________________________________

Cocaine: ____________________________Usage_____________________________________

Amphetamines: ______________________Usage_____________________________________

Opioids: _____________________________Usage_____________________________________

Treatment history:

____

____

Willing to attend treatment now? __________

PSYCHIATRIC ISSUES AND TREATMENT HISTORY:

Mental health diagnosis:

____

____

Mental health treatment history:

____

____

Medication(s): ____

____

Hospitalization(s): ____

Suicide History

Comprehensive suicide risk assessment: ____

SUICIDE RISK LEVEL (Last 2 yrs) ____

SUICIDE RISK LEVEL (current) ____

History of aggression: ____

Safety risk factors: ____

Mental Health Treatment Provider:

Name: ____

Number: ____

Location: ____

LEGAL ISSUES:

Current legal issues: ____

Past legal issues: ____

Warrants: ____

Registered Sex Offender_____

Pyromaniac/Arsonist________

STABILIZATION NEEDS:

Present issues needing stabilization: ____

Proposed length of stay at contract bed: ____

Proposed plan once stabilized: ____

Referrals provided: ____

Complete form and FAX, along with the Release of Medical Records or Health Information, to:

VA Recuperative Care Liaison

Office number: (858) 642-1556

Cell number: (858)232-7991

Fax number: (858) 404- 8371