

## Instructions

**\*\*\*If the veteran is being referred from a community facility or by an individual and NOT from another VA hospital or facility, please send the additional information listed here along with the completed admission request form on page 2 and a completed Form 1010 EZ to help determine the veteran's eligibility for medical benefits. This form can be found the Tuscaloosa VA web page. Click this link to go there now: <https://www.1010ez.med.va.gov/sec/vha/1010ez/>**

MAR for the last 7-days	_____
* Discharge Medication list and their indications	_____
Allergies	_____
PPD and Recent Immunizations	_____
Chest x-ray (no more than 30-days old)	_____
Recent Labs	_____
H&P	_____
Physicians Notes regarding treatment received and current, status	_____
Procedures and follow-ups	_____
OT/PT/KT, Speech notes and any other specialties	_____
Social work and psychosocial notes	_____
Skin condition (decubiti, skin tears etc)	_____
Discharge Plan (detailed information)	_____

IF veteran has **Dementia** diagnosis: include **CT of head** and physician's note stating Dementia, date of **Dementia** diagnosis. **Dementia Labs:** B12, Folate, RPR, TSH

IF veteran is **Hospice**: include physician's note stating Hospice diagnosis (**with prognosis 6 months or less**)

If there are questions about admission forms, contact the Admissions Coordinator, (205) 554-2000 ext. 2551.

Eligibility questions call: (205) 554-2000, ext. 2888.

Office hours: Monday through Friday 8:00am – 4:30pm.

To fax completed forms, send to (205) 554-2083.

# Tuscaloosa VA Medical Center Admission Request

## Check program for which you are requesting admission:

- Valor Rehabilitation Center
- Community Living Center (nursing home)
- Respite Care
- Hospice Center (end-of-life)

**Criteria for Eligibility:** All applicants must be enrolled and eligible for VA services that require an updated (within the year) Form 1010EZ. All non-service connected veterans require completion of a 10-10EC (long-term co-pay test) to determine estimated co-pay for treatment. If there are questions about eligibility, contact 205-554-2000 ext 2228.

Date of Request: \_\_\_\_\_

### Demographics -

- Patient Name: \_\_\_\_\_
- SSN: \_\_\_\_\_
- Current Location of Patient: \_\_\_\_\_
- If patient is currently in a Health Care Center, please provide:
  - Name of Treating Physician: \_\_\_\_\_
  - Physician Phone Number and Pager number: \_\_\_\_\_
- Social Worker/Case Manager (name): \_\_\_\_\_  
Phone #: \_\_\_\_\_
- Family Contact (name): \_\_\_\_\_  
Phone #: \_\_\_\_\_
- Name/phone number of contact if additional information for admission request is needed: \_\_\_\_\_

### 1. Diagnosis/Current Status and Prognosis -

- Reason for Referral - \_\_\_\_\_
- Primary Diagnosis - \_\_\_\_\_
- Secondary Diagnoses: 1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_
- Is your request related to surgery?  
\_\_\_\_ Yes Date of surgery: \_\_\_\_\_  
\_\_\_\_ No Type of Surgery: \_\_\_\_\_
- Mental Status (check all that apply):
  - Alert \_\_\_\_\_
  - Confused \_\_\_\_\_
  - Disoriented \_\_\_\_\_
  - Agitated \_\_\_\_\_
- Recent change in mental status: Yes \_\_\_\_\_ No \_\_\_\_\_
- Does the veteran have a history of mental illness?  
Yes \_\_\_\_\_ No \_\_\_\_\_
- Does the veteran have a diagnosis of dementia? (if yes, please provide a date and copies of work up supporting diagnosis)  
Yes \_\_\_\_\_ No \_\_\_\_\_

- Does the veteran have a terminal illness? (if yes and applying for Hospice, please provide a physician statement with the admission request application)  
Yes \_\_\_\_\_ No \_\_\_\_\_
- Has the veteran fallen within the past 3 months?  
Yes \_\_\_\_\_ No \_\_\_\_\_ Date of last fall if known \_\_\_\_\_
- Is veteran a wandering risk?  
Yes \_\_\_\_\_ No \_\_\_\_\_
- Does veteran have a history of being assaultive?  
Yes \_\_\_\_\_ No \_\_\_\_\_
- Are restraints being used?  
Yes \_\_\_\_\_ Give date they were discontinued \_\_\_\_\_ No \_\_\_\_\_
- Is veteran receiving any type of the following treatments:
  - Dialysis Yes \_\_\_\_\_ No \_\_\_\_\_
  - Radiation Yes \_\_\_\_\_ No \_\_\_\_\_
  - Chemotherapy (oral or parenteral) Yes \_\_\_\_\_ No \_\_\_\_\_
  - BiPAP/CPAP Yes \_\_\_\_\_ No \_\_\_\_\_
  - Oxygen Yes \_\_\_\_\_ No \_\_\_\_\_
  - IV Fluids Yes \_\_\_\_\_ No \_\_\_\_\_
  - IV Antibiotics Yes \_\_\_\_\_ No \_\_\_\_\_
  - Tube Feedings Yes \_\_\_\_\_ No \_\_\_\_\_

2. Functional Status

	Independent	Dependent	Minimum Assist	Maximum Assist
• Walking	_____	_____	_____	_____
• Transfers	_____	_____	_____	_____
• Climbing Stairs	_____	_____	_____	_____
• Dressing, upper	_____	_____	_____	_____
• Dressing, lower	_____	_____	_____	_____
• Toileting	_____	_____	_____	_____
• Eating	_____	_____	_____	_____

3. Additional Care Needs –

- Patient has indwelling catheter - Yes \_\_\_\_\_ No \_\_\_\_\_  
Suprapubic catheter - Yes \_\_\_\_\_ No \_\_\_\_\_  
Size \_\_\_\_\_ Last changed \_\_\_\_\_
- IV/PICC/Central Line/PCA - Yes \_\_\_\_\_ No \_\_\_\_\_  
Type \_\_\_\_\_ Size \_\_\_\_\_  
Date Last changed: \_\_\_\_\_
- Oxygen Concentrate: Yes \_\_\_\_\_ No \_\_\_\_\_  
Type \_\_\_\_\_ L/minute \_\_\_\_\_
- Ventilator Yes \_\_\_\_\_ No \_\_\_\_\_
- Tracheostomy - Yes \_\_\_\_\_ No \_\_\_\_\_  
Size \_\_\_\_\_ Type \_\_\_\_\_
- Assistive/Adaptive devices - Yes \_\_\_\_\_ No \_\_\_\_\_ Type \_\_\_\_\_

- PEG Tube: Yes \_\_\_\_\_ No \_\_\_\_\_  
Type\_\_\_\_\_
- Ostomy: Yes \_\_\_\_\_ No \_\_\_\_\_  
Type\_\_\_\_\_
- Skin/Wound Care Needs Yes \_\_\_\_ No \_\_\_\_  
Type\_\_\_\_\_
- Does the veteran require bariatric equipment? Yes \_\_\_\_\_ No \_\_\_\_\_  
Type\_\_\_\_\_
- Is the veteran blind?  
Yes \_\_\_\_\_ (please check which eye: \_\_\_\_\_Left \_\_\_\_\_Right \_\_\_\_\_Both)  
No \_\_\_\_\_
- Does the veteran have a hearing problem?  
Yes \_\_\_\_\_ (please check which ear: \_\_\_\_\_Left \_\_\_\_\_Right \_\_\_\_\_Both)  
No \_\_\_\_\_

4. Social Status/Support System (explain): \_\_\_\_\_

- Discharge Plan (please provide information on where vet will be discharged at end of treatment ):  
\_\_\_\_\_
- Is there a placement issue? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please explain\_\_\_\_\_
- Is the veteran a Do Not Resuscitate (DNR)? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please attach form.
- Does the veteran have a living will or durable power of attorney? (if yes please provide a copy upon admission) Yes\_\_\_\_\_ No \_\_\_\_\_

5. Other comments/information: \_\_\_\_\_.

**\*\*\* Completed this section only if requesting Rehab (Valor Unit) placement:**

Is patient able to tolerate the acute rehab intensity of care?

Yes \_\_\_\_\_ No \_\_\_\_\_ If no, please explain. \_\_\_\_\_.

Is the patient willing to actively participate in acute rehabilitation for 3 hours a day? \_\_\_\_\_

If not, is patient aware that refusal to participate will likely result in his/her discharge? \_\_\_\_\_

\*Sign and date one of the following Memoranda of Understanding to the program for which you are applying and send with the application.

**\*\*Sign and date ONLY if requesting admission to the TVAMC Valor Rehabilitation Center.**

Tuscaloosa VA Medical Center  
Valor Rehabilitation Center Memorandum of Understanding

We are pleased that you have chosen the TVAMC. Our inpatient rehabilitation program provides comprehensive assessment and treatment by physical, occupational, recreation, speech therapists, and kinesiotherapists. Other members of the healthcare team include the physician, dietitian, social worker, case manager, and psychologist. You and your family make up an important part of your treatment team and active participation in your care is encouraged. Our goal is to provide maximal improvement in your ability to move and care for yourself.

Our rehabilitation program is not intended to be a permanent place to live. The usual length of stay on our acute rehabilitation unit is 21-28 days. Upon completion of the treatment program, discharge to home or another facility in the community will be pursued. This discharge planning is started at the time of admission.

The above has been discussed with me, and I understand the purpose and limitations of length of stay in the Valor Center for Rehabilitation Program Unit.

\_\_\_\_\_  
Veteran patient

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Family Member/Relationship

\_\_\_\_\_  
Date

**\*\*Sign and date ONLY if requesting admission to Hospice Unit.**

Tuscaloosa VA Medical Center  
Honors Way (Hospice) Statement of Understanding

I choose to receive inpatient hospice care on Honors Way at TVAMC. In electing to receive hospice care, I acknowledge and understand the following:

1. Hospice care is palliative, not curative, in its goals. This means that the program does not attempt to cure disease, but emphasizes the relief of symptoms such as pain, physical discomfort, and emotional distress that may accompany a life-threatening illness.
2. Since it is not likely that my condition will improve, treatment efforts will be focused toward comfort instead of toward cure or prolonging survival.
3. My care will be directed toward the provision of psychological, emotional, social and spiritual support for myself, my family and/or other significant persons.
4. Patients admitted to Honors Way for hospice care are required to have an active "Do Not Resuscitate" (DNR) order in their medical record.
5. I can request home hospice care if there is a home setting that is able to meet my needs for care.
6. I can choose to discontinue hospice care at any time. I must request discontinuation of hospice care in writing. However, if I choose to discontinue hospice care, that choice may affect my eligibility for nursing home care at the Tuscaloosa VA Medical Center.

\_\_\_\_\_  
Signature of Patient or Authorized Representative

\_\_\_\_\_  
Date

**\*\*Sign and date ONLY if requesting admission to Short-Term Evaluation**

Tuscaloosa VA Medical Center Veteran/Caregiver Agreement to Short-Term Evaluation and Rehabilitation Statement of Understanding

1. The following paragraphs provide information to the reader regarding the short-term Evaluation and Rehabilitation Program offered by the Tuscaloosa VA Medical Center. It is essential that all candidates for this program and their care providers be familiar with the purpose and intent of short-term evaluation and rehabilitation.
  - a. The primary purpose of this program is to improve or stabilize the condition and/or functional status of eligible veterans with a goal of discharge home or to an appropriate community setting. This program is not a long term care placement. On the contrary, the focus of short-term evaluation and rehabilitation is to prevent or postpone long-term institutional care as long as possible.
  - b. Discharge and aftercare planning is a critical component of short-term rehabilitation and will be initiated prior to admission to the program. Veterans/caregivers who do not have viable discharge plans will not be admitted to the short-term Evaluation and Rehabilitation Program.
  - c. Comprehensive and interdisciplinary diagnostic assessment will be provided and treatment intervention initiated with specifically stated goals for improvement or stabilization of the patient. The veteran/family is expected to be active participants in the assessment, care planning, and discharge planning process.
  - d. The maximum length of stay for the short-term evaluation and rehabilitation program is 90 days.

2. I have read the above program description of the short-term Evaluation and Rehabilitation Program. I understand the program goals, length of stay limits and agree to cooperate in the treatment program and discharge planning. I further understand that failure to comply with the discharge plan may result in placement of the veteran in the most readily available community setting at the veterans' expense.

Address of Discharge Placement:

\_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Veteran/Power of Attorney

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Caregiver