

MEDICAL REPORT FOR ADMISSION TO NEBRASKA VETERANS' HOME

Patient Name: _____ Birth Date: _____ Male Female

I hereby, authorize the release of necessary medical information from hospitals and other medical providers to the Nebraska Health and Human Services, the Nebraska Department of Veterans' Affairs, the appropriate County Veterans' Service Office, and the Veterans' Homes Board in order to establish eligibility for admission to the Nebraska Veterans' Home System.

Date: _____ Patient or Authorized Signature: _____

ALL SECTIONS MUST BE COMPLETED. IF IT DOES NOT APPLY MARK WITH N/A OR NONE.

Does patient have capacity to make health care decisions? Yes No

Diagnosis (include alcoholism, drug abuse and psychopathology)

- | | | |
|----------|----------|----------|
| 1. _____ | 2. _____ | 3. _____ |
| 4. _____ | 5. _____ | 6. _____ |
| 7. _____ | 8. _____ | 9. _____ |

CHECK ANY OF THE FOLLOWING IF THEY ARE PRESENT:

Disabilities	Impairments	Mild	Mod.	Sev.	Activity Tol. Limits	Test	Date	Results
<input type="checkbox"/> Amputation	Speech				<input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	Chest x-ray		
<input type="checkbox"/> Paralysis	Hearing					C.V.C.		
<input type="checkbox"/> Contracture	Vision					Serology		
<input type="checkbox"/> Decub. Ulcer	Sensation					Urinalysis		
<input type="checkbox"/> Other	Tremors							

Infections - please specify (MRSA, VRE, IV antibiotics, etc.)

None

- | | | | |
|--|------------------------------|-----------------------------|-------------|
| <input type="checkbox"/> Tetanus Shot | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Date: _____ |
| <input type="checkbox"/> Influenza Shot | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Date: _____ |
| <input type="checkbox"/> Pneumococcal Polysaccharide Vaccine | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Date: _____ |

Behavioral issues - please specify (wandering, anger, etc.)

- | | | |
|---|---|---|
| <input type="checkbox"/> Wandering | <input type="checkbox"/> Anger Outbursts | <input type="checkbox"/> Delusional Behaviors |
| <input type="checkbox"/> Resists cares | <input type="checkbox"/> Sexual Inappropriateness | <input type="checkbox"/> None |
| <input type="checkbox"/> Compulsive Behaviors | Specify: _____ | |

Present Medications: (an attached printout is acceptable)

- | | | | |
|----------|-----------|-----------|-----------|
| 1. _____ | 2. _____ | 3. _____ | 4. _____ |
| 5. _____ | 6. _____ | 7. _____ | 8. _____ |
| 9. _____ | 10. _____ | 11. _____ | 12. _____ |

Allergies - please specify NKA _____

Diet: Regular Modified (specify e.g., salt free, 1800 calorie limit etc.)

Patient

Acceptance of illness / disability	Understands reason for placement	Participated in Plan
<input type="checkbox"/> Good	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
<input type="checkbox"/> Fair	<input type="checkbox"/> Partly	<input type="checkbox"/> No
<input type="checkbox"/> Poor	<input type="checkbox"/> No	<input type="checkbox"/> N/A

Family

Participated in Planning	Accepted Nursing Home Plan	Expected to Visit
<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
<input type="checkbox"/> No	<input type="checkbox"/> Reluctantly	<input type="checkbox"/> No
<input type="checkbox"/> N/A	<input type="checkbox"/> No	<input type="checkbox"/> N/A

Patient Name: _____ **Social Security #** _____

Self-Care Status:	Needs Assistance			Assistive Devices:	Assistive Devices		
	Independent	Needs Assistance	Unable to do		Has	Uses	Needs
Personal Hygiene				Eyeglasses			
				Dentures			
Feeding				Hearing Aid			
				Walker			
Locomotion				Crutches			
				Cane			
Transfers				Wheelchair			
				Other: (specify)			
Elimination:	Ostomy	Continent	Incontinent				
Bowel				Remarks:			
Bladder							

Patient's Sociability:

Sociable Withdrawn at times Combative

Patient's Mental Status:

Alert / Oriented / Responsive Diagnosed Dementia
 Occasionally Disoriented / Confused Hospitalized for Psychiatric Treatment
 Diagnosed Mental Illness

Does Patient Know Diagnosis? Yes No

Other: (Include observations, instructions given to patient / family regarding illness, treatment, etc.)

None

PHYSICIAN'S RECOMMENDATIONS

Special Treatments:

None

Feeding Tube

Oxygen

Specify: _____

Physician's Printed Name, Address & Telephone No.

Name: _____

Address: _____

City, St. Zip: _____

Telephone: _____

SIGNATURE & DATE: X

Prognosis:

Anticipated Rehabilitation Needs:

None

Anticipated Level of Care:

PLEASE RECHECK TO MAKE SURE ALL SECTIONS ARE COMPLETED OR THIS FORM WILL BE RETURNED