OMB Approval No. 2900-0160
Estimated Burden: Avg. 30 min.

Department of Veterans Affairs

STATE HOME PROGRAM APPLICATION FOR VETERAN CARE MEDICAL CERTIFICATION

PART I - ADMINISTRATIVE

STATE HOME FACILITY	DATE ADMITTED	GENDER M F
RESIDENT'S NAME (*Last, First, Middle*)	SOCIAL SECURITY NUMBER	
RESIDENT'S STREET ADDRESS	AGE	DATE OF BIRTH
CITY, STATE AND ZIP CODE	ADVANCED MEDICAL DIRECTIVE NO YES	

PART II - HISTORY AND PHYSICAL *(Use separate sheet if necessary)*

HISTORY

HEIGHT	WEIGHT	TEMP	PULSE	BP	HEAD/EYES/EAR/NOSE AND THROAT

NECK	CARDIOPULMONARY
ABDOMEN	GENITOURINARY
RECTAL	EXTREMITIES
NEUROLOGICAL	ALLERGY/DRUG SENSITIVITY

X-RAY/ LAB	CHEST X-RAY	DATE:	RESULTS	CBC	DATE:	RESULTS
	SEROLOGY					
	URINALYSIS	DATE	ALBUMEN	SUGAR		ACETONE

CHECK ALL BOXES THAT APPLY OR CIRCLE NA

IS DEMENTIA THE PRIMARY DIAGNOSIS	IS THERE A DIAGNOSIS OF MENTAL ILLNESS	HAS RESIDENT RECEIVED MENTAL SERVICES WITHIN THE PAST 2 YEARS	IS CLIENT A DANGER TO SELF OR OTHERS
YES NO	YES NO	YES NO	YES NO

IS THERE ANY PRESSING EVIDENCE OF MENTAL ILLNESS SUCH AS:

SCHIZOPHRENIA PARANOIA OTHER PSYCHOTIC OR MENTAL DISORDERS LEADING TO CHRONIC DISABILITY

MOOD SWINGS SOMATOFORM DISORDER PANIC OR SEVERE ANXIETY DISORDER PERSONALITY DISORDER

OXYGEN		TUBE FEEDING	DECUBITUS ULCERS	FOLEY CATHETER
MASK	PRN	OSTOMY	DRAINING WOUND	TEMPORARY
NASAL CANULAR	CONTINUOUS	TRACHOSTOMY	WOUND CULTURED	PERMANENT

REFERRING PHYSICIAN	PRIMARY DIAGNOSIS
SECONDARY DIAGNOSIS	TERTIARY DIAGNOSIS

TYPE OF CARE RECOMMENDED: SKILLED NURSING HOME CARE DOMICILIARY CARE ADULT DAY HEALTH CARE HOSPITAL

MEDICATION AND TREATMENT ORDERS ON ADMISSION, CONTINUE ON SEPARATE SHEET IF NECESSARY

PRINTED OR TYPED NAME OF PRIMARY PHYSICIAN ASSIGNED	SIGNATURE OF PRIMARY PHYSICIAN ASSIGNED