



**STATE HOME PROGRAM APPLICATION FOR VETERAN CARE
MEDICAL CERTIFICATION**

PART I - ADMINISTRATIVE

STATE HOME FACILITY		DATE ADMITTED	GENDER <input type="checkbox"/> M <input type="checkbox"/> F
RESIDENT'S NAME (Last, First, Middle) (This is a mandatory field)		SOCIAL SECURITY NUMBER. (Mandatory field)	
RESIDENT'S STREET ADDRESS		AGE	DATE OF BIRTH (mm/dd/yyyy)
CITY, STATE AND ZIP CODE		ADVANCED MEDICAL DIRECTIVE <input type="checkbox"/> NO <input type="checkbox"/> 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 (mm/dd/yyyy)	RESULTS	CBC	DATE (mm/dd/yyyy)	RESULTS
	SEROLOGY					
	URINALYSIS	DATE (mm/dd/yyyy)	ALBUMEN	SUGAR	ACETONE	

CHECK ALL BOXES THAT APPLY OR CHECK NA

IS DEMENTIA THE PRIMARY DIAGNOSIS <input type="checkbox"/> YES <input type="checkbox"/> NO	IS THERE A DIAGNOSIS OF MENTAL ILLNESS <input type="checkbox"/> YES <input type="checkbox"/> NO	HAS RESIDENT RECEIVED MENTAL SERVICES WITHIN THE PAST 2 YEARS <input type="checkbox"/> YES <input type="checkbox"/> NO	IS CLIENT A DANGER TO SELF OR OTHERS <input type="checkbox"/> YES <input type="checkbox"/> NO
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IS THERE ANY PRESSING EVIDENCE OF MENTAL ILLNESS SUCH AS:

<input type="checkbox"/> SCHIZOPHRENIA	<input type="checkbox"/> PARANOIA	<input type="checkbox"/> OTHER PSYCHOTIC OR MENTAL DISORDERS LEADING TO CHRONIC DISABILITY
<input type="checkbox"/> MOOD SWINGS	<input type="checkbox"/> SOMATOFORM DISORDER	<input type="checkbox"/> PANIC OR SEVERE ANXIETY DISORDER
		<input type="checkbox"/> PERSONALITY DISORDER

<input type="checkbox"/> MASK	<input type="checkbox"/> PRN	<input type="checkbox"/> TUBE FEEDING	<input type="checkbox"/> DECUBITUS ULCERS	FOLEY CATHETER
<input type="checkbox"/> NASAL CANULAR	<input type="checkbox"/> CONTINUOUS	<input type="checkbox"/> OSTOMY	<input type="checkbox"/> DRAINING WOUND	<input type="checkbox"/> TEMPORARY
		<input type="checkbox"/> TRACHOSTOMY	<input type="checkbox"/> WOUND CULTURED	<input type="checkbox"/> PERMANENT

REFERRING PHYSICIAN	PRIMARY DIAGNOSIS
SECONDARY DIAGNOSIS	TERTIARY DIAGNOSIS

TYPE OF CARE RECOMMENDED: SKILLED NURSING HOME CARE DOMICILIARY CARE ADULT 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
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