SOLDIER ON

The Fight Doesn't End When They Get Home

Referral/Level of Care Assessment Form

(Part 1)

Referring Agency_____Date_____

Referring Person_____Telephone # (___) _____

Veteran's Name_____SS#_____

DOB _____ Previous Admission to Soldier On? Yes No Date_____

Branch of Service _____ DD214 Yes No
Discharge Status_____ VA Eligible? Yes No

Court Involvement_____Charges_____
Court/PO_____ Date of Next Appearance_____

Is the Prospective Resident Legally Competent? Yes No
Is there a Health Proxy in place? Yes No
Name_____Contact #_____

Does Prospective Resident have a history with Arson? Yes No
Suicidal Ideation? Yes No History of Violence: Yes No _____
_____
Has Prospective Resident ever been charged or convicted of a Sexual Offense? Yes No
(If yes acceptance criteria must be followed) Explain:_____
_____
_____

Substance Abuse History: Engaged in Treatment?_____ _____
Primary Drug of Choice: _____Last drink/drug use :_____
Is Prospective Resident scheduled to enter a substance abuse treatment program? Yes No
If yes Where & When_____
Is Prospective Resident involved in a methadone maintenance program? Yes No
If yes Where & When_____

Health Insurance? Yes No Provider_____
Medical Issues: Yes No _____
Medical Diagnosis:_____
Medications for Medical Issues: _____
_____
Medical Information:_____
_____
_____

Mental Health Issues ☐Yes ☐No Diagnosis:_____
_____
_____
Medications for Mental Health Issues: _____
_____
_____
Psychiatric Hospitalizations:_____
_____
_____

Occupation: _____ **Date last worked:** _____
Income Source:_____ _____**Amount: $**_____
Marital Status: _____ **Spouse Name:**_____
Children: _____ _____
_____
Family Involvement/Positive Supports:_____
_____
_____
_____

Please provide a Brief Description of Referents Current Needs (Including what has created need for housing, personal needs, strengths, any information that can assist Soldier On in determining eligibility:_____
_____
_____
_____
_____
_____
_____
_____
_____

UPON ADMISSION PROSPECTIVE RESIDENT WITH NEED TO HAVE THE FOLLOWING DOCUMENTATION:
***DD2-14**
***BIRTH CERTIFICATE**
***DRIVERS LISCENCE/ VALID IDENTIFICATION**
***SOCIAL SECURITY CARD**
***2 WEEKS OF MEDICATION FOR ALL PSYCHIATRIC AND MEDICAL NEEDS**
***PSY/SOCIAL REPORT FROM REFERRAL SOURCE**
***HEALTH CARE PROXY (IF ONE IN PLACE)**

SOLDIER ON

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Referral/Level of Care Assessment Form

(Part 2)

Basic Information

Prospective Resident's Name:_____

Age:_____ ☐**Male**☐**Female** **Height**_____ **Weight**_____

Activities of Daily Living

ADL General	No Help Needed (Independent)	Some Help Needed	Extensive Total Help
Dressing: Upper Body	☐	☐	☐
Dressing: Lower Body	☐	☐	☐
Hygiene: Hands, Face	☐	☐	☐
Hygiene: Hair,Teeth,Shaving	☐	☐	☐
Hygiene: Showering	☐	☐	☐
Locomotion: Walking, Wheelchair	☐	☐	☐
Dining: Set Up, Self Feeding	☐	☐	☐
Mobility: In/Out Bed, Chair	☐	☐	☐
Mobility	☐ walker	☐ wheelchair	☐ both
Bowel/Bladder			
Bowel: Continence needs	☐	☐	☐
Bladder: Incontinence needs	☐	☐	☐

Mental/Cognitive Status

Alert/Orientated (time, place person)	☐Yes	☐No
Memory Loss (short term)	☐Yes	☐No
Memory Loss (long term)	☐Yes	☐No
Wanders	☐Yes	☐No
Any challenging behaviors?*	☐Yes	☐No

*This includes information such as being disruptive, agitated, or aggressive, abusive, demanding, and/or requiring frequent staff interventions. Is this prospective resident delusional or has hallucinations? Please describe prospective resident's emotional status, personality, and demeanor;_____

_____

_____

_____

Signature of Person Completing this form:

_____

Name Contact #

Return completed form to: Soldier On, Intake Coordinator. Fax # 1-413-582-3035