

Referral/Level of Care Assessment Form

Referring Agency _____ Date _____

Referring Person _____ Telephone # (____) _____

Veteran's Name _____ SS# _____

DOB _____ Telephone # (____) _____

Previous Admission to Soldier On? Yes No

Branch of Service _____ DD214 Yes No

Discharge Status _____ VA Eligible Yes No

Does Prospective Residents have an apartment or house in his/her name? 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

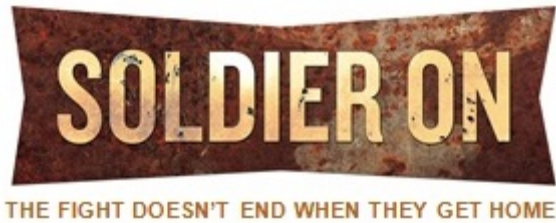
Name _____ Telephone # (____) _____

Does Prospective Resident have a history of Arson? Yes No

Suicidal Ideation? Yes No History of Violence? Yes No If yes, explain. _____

Has Prospective Resident ever been charged or convicted with 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, When & Where: _____

Is Prospective Resident involved in a methadone maintenance program? Yes No

If Yes, When & Where: _____

Health Insurance Yes No Provider: _____

Medical Issues: Yes No _____

Medical Diagnosis: _____

Medications for Medical Issues _____

Medical Information _____

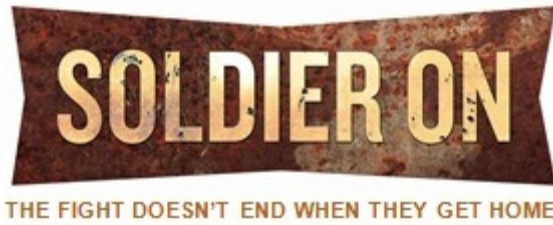
Do you have a Medical Marijuana Card: Yes No

Mental Health Issues Yes No

Diagnosis: _____

Medications for Mental Health Issues _____

Psychiatric Hospitalization _____



Occupation _____ Date last worked _____

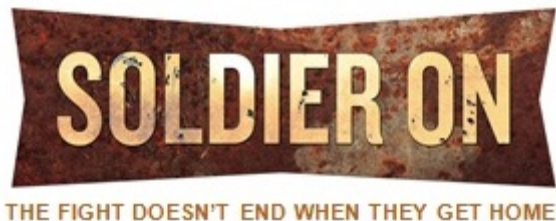
Income Source _____ Amount \$ _____

Marital Status _____ Spouse _____

Children: _____

Family Involvement/Positive Supports: _____

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



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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dressing: Lower Body	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hygiene: Hands, Face	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hygiene: Hair,Teeth,Shaving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hygiene: Showering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Locomotion: Walking, Wheelchair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dining: Set Up, Self Feeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mobility: In/Out Bed, Chair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mobility	<input type="checkbox"/> walker	<input type="checkbox"/> wheelchair	<input type="checkbox"/> both

Bowel/Bladder

Bowel: Continence needs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bladder: Incontinence needs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Mental/Cognitive Status

Alert/Orientated (time, place person)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Memory Loss (short term)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Memory Loss (long term)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Wanders	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any challenging behaviors?*	<input type="checkbox"/> Yes	<input type="checkbox"/> No

*This includes things like 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:

Return completed form to: Soldier On, Intake Coordinator. Fax # 1-413-582-3075