Referral/Level of Care Assessment Form

Referral Form must be filled out by service provider

Referring Agency_____**Date**_____

Referring Person_____ **Telephone # (_____)** _____

Veteran's Name_____**SS#**_____

DOB _____**Veterans Telephone # (_____)** _____

Current Address _____

Does Prospective Residents have an apartment or house in his/her name? ◯**Yes** ◯**No**

Is this Referral being completed by a referring VA? ◯**Yes** ◯**No**

Is there a Behavioral or High-Risk Flag? ◯**Yes** ◯**No**

If yes, explain. _____

_____

Previous Admission to Soldier On? ◯**Yes** ◯**No** **Date** _____

Branch of Service _____ **DD214** ◯**Yes** ◯**No**

Discharge Status _____ **VA Eligible** ◯**Yes** ◯**No**

Court Involvement? ◯**Yes** ◯**No** **Charges**_____

Name of Court _____**Date of Next Appearance**_____

PO Name _____ **Telephone # (_____)** _____

Attach Court Conditions

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**

History of Suicidal Ideation? ◯**Yes** ◯**No** **Last Date** _____

History of Suicide Attempts? ◯**Yes** ◯**No** **Last Date** _____

History of Violence? ◯**Yes** ◯**No** **Last Date** _____

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? ◯Yes ◯No

Dates of Current Treatment _____Where_____

Date of Previous Treatment _____Where_____

Date of Previous Treatment _____Where_____

Date of Previous Treatment _____Where_____

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: _____

Does Prospective Resident have a Medical Marijuana Card: ◯Yes ◯No

Medical History

Health Insurance ◯Yes ◯No Provider: _____

Chronic Medical Issues: ◯Yes ◯No If Yes, Explain_____

_____

_____

Acute Medical Issues: ◯Yes ◯No If Yes, Explain_____

_____

_____

Medical Diagnosis:_____

_____

Medications for Medical Issues:_____

_____

_____

Currently Impatient for a Medical Issue? ◯Yes ◯ No If Yes, Explain_____

_____

_____

_____

Mental Health

Mental Diagnosis:_____

_____

Attach Current Psychosocial

Current Prescribed Medication_____

_____

Psychiatric Hospitalization? ◯Yes ◯ No

Dates of Current Hospitalization_____**Where**_____

Date of Previous Hospitalization _____ **Where**_____

Date of Previous Hospitalization _____ **Where**_____

Date of Previous Hospitalization _____ **Where**_____

Source of Income

Occupation _____ **Date last worked** _____

Income Source _____**Amount $**_____

Family Information

Marital Status _____ **Name of Spouse**_____

Name of 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: _____ **Sex:** ◯ **Male** ◯ **Female** **Gender:** _____ **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 disruptive, agitated, aggressive, abusive, demanding behavior, and/or behavior 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: _____