

**Inter-Facility Request For Home Care Coordination To Be Provided By The
DAYTON VA MEDICAL CENTER**



Instructions:

- 1) Home Health Care paid for and arranged by the Dayton VA must be ordered by a VA Provider. If care is being arranged through Medicare directly by discharging facility, please complete this form for the information of the VA Provider in order to sign subsequent plans of care.
- 2) Note that this form is for treatment recommendations by the discharging facility and this will be reviewed and ordered at the discretion of the VA Provider if deemed appropriate.
- 3) VA Provider may require a face to face appointment prior to orders if Veteran has not been examined recently.
- 4) Please complete this form and send along with the following information:
 - a. History and Physical
 - b. Discharge instructions and discharge summary if available
 - c. Current Medication list
- 5) Fax copies to **BOTH**: Appropriate Primary Care clinic listed to the right **and** to Community Health at (937) 267-7593, giving as much notice as possible, at least one business day.

Phone: 937-267-5369
 Fax to:
 Dayton 937-267-5316
 Lima 419-222-9504
 Middletown 513-423-3309
 Richmond 765-965-6936
 Springfield 937-328-3387

Veteran Name:		Last 4# of Social Security:	
Address:		Phone #:	
VA Primary Care Provider:		Date of Birth:	
Discharging Hospital:		Anticipated date of DC:	
Diagnosis:	Discharge Planner (Name and phone #):		
Discharging MD:			

Veteran's Home Care Needs: List Details below

Skilled Nursing Yes No

<p>Wound care <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Type & location of wound: Dressing type: Frequency: Supplies needing to be ordered:</p>
---	---

Medication Management Yes No

<p>IV Therapy: <input type="checkbox"/> Yes</p>	<p>Medication: Dose: Frequency: Has Veteran received first dose in-house? <input type="checkbox"/> Yes <input type="checkbox"/> No Access type:</p>
--	---

<p>Injection: <input type="checkbox"/> Yes</p>	<p>Medication: Dose: Frequency: Has Veteran received first dose in-house? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
---	---

Education: Yes No Comment:

Mediplanner fills: Yes No Frequency:

Assessment Yes No Body System:

Other Procedures Yes No Oxygen:

<p>Trach care <input type="checkbox"/> Yes</p>	<p>Needed equipment:</p>
---	--------------------------

<p>PEG care <input type="checkbox"/> Yes</p>	<p>Tube feeding type & freq:</p>
---	--------------------------------------

<p>Catheter care <input type="checkbox"/> Yes</p>	<p>Type, size and last date of change:</p>
--	--

<p>Blood work <input type="checkbox"/> Yes</p>	<p>Type and frequency:</p>
---	----------------------------

<p>Other <input type="checkbox"/> Yes</p>	
--	--

In-Home Therapy: Yes No

Physical Therapy Occupational Therapy Speech Therapy

Goals:

Home Health Aide for Personal Care: Yes No **Currently has agency?** Yes No

Name of Agency Veteran Prefers:

General Comments: