



MISSOURI VETERANS COMMISSION
 MISSOURI VETERANS HOME
HEALTH CARE INFORMATION

INSTRUCTIONS

1. All information must be printed or typed. Attach additional sheets if necessary.
2. Form must be completed by licensed health care professional. Mail form to; (Check below)

Missouri Veterans Home
 1111 Euclid
 Cameron, MO 64429
 (816) 632-6010 FAX (816) 632-1361

Missouri Veterans Home
 2400 Veterans Memorial Drive
 Cape Girardeau, MO 63701
 (573) 290-5870 FAX: (573) 290-5909

Missouri Veterans Home
 #1 Veterans Drive
 Mexico, MO 65265-0473
 (573) 581-1088 FAX: (573) 581-5356

Missouri Veterans Home
 1600 South Hickory
 Mt. Vernon, MO 65712-1098
 (417) 466-7103 FAX: (417) 466-4040

Missouri Veterans Home
 620 North Jefferson
 St. James, MO 65559-1999
 (573) 265-3271 FAX: (573) 265-5771

Missouri Veterans Home
 10600 Lewis and Clark Blvd.
 St. Louis, MO 63136
 (314) 340-6389 FAX: (314) 340-6379

Missouri Veterans Home
 1300 Veterans Road
 Warrensburg, MO 64093
 (660) 543-5064 FAX (660) 543-5075

GENERAL INFORMATION

PATIENT'S NAME			BIRTHDATE
PLACE OF RESIDENCE AT TIME OF APPLICATION			SOCIAL SECURITY NUMBER
CITY	STATE	ZIP CODE	TELEPHONE NUMBER ()

HISTORY/PHYSICAL INFORMATION

HEIGHT	WEIGHT	REQUIRES NURSING HOME CARE? <input type="checkbox"/> YES <input type="checkbox"/> NO <small>NOTE: CHECKING "YES" INDICATES THE VETERAN IS IN NEED OF LONGTERM SKILLED NURSING CARE. CHECKING "NO" INDICATES VETERAN IS NOT IN NEED OF LONGTERM SKILLED NURSING HOME CARE.</small>
DATE OF LAST TETANUS	DATE OF LAST PNEUMOVAX	HISTORY OF DRUG/ALCOHOL ABUSE? <input type="checkbox"/> YES <input type="checkbox"/> NO
IMMUNIZATIONS	SPECIFY ALLERGIES	HISTORY OF MENTAL ILLNESS? <input type="checkbox"/> YES <input type="checkbox"/> NO <small>IF APPLICANT HAS A PSYCHIATRIC DIAGNOSIS, PLEASE ATTACH A COPY OF MOST RECENT PSYCHIATRIC EVALUATION.</small>

ILLNESSES, SURGICAL PROCEDURES, HOSPITALIZATIONS

PRESENT CONDITION AS COMPARED TO ANY PREVIOUS EXAMINATION

DIAGNOSIS(ES)

MEDICATION

LIST ALL MEDICATIONS, DOSAGE AND FREQUENCY OF ADMINISTRATION OR ATTACH A COPY OF THE CURRENT PHYSICIAN ORDERS.

HEALTH CARE INFORMATION CONTINUED

FUNCTIONAL INFORMATION PERTINENT NURSING INFORMATION

CHECK IF PRESENT AND DESCRIBE IN "PERTINENT NURSING INFORMATION" SECTION

DISABILITIES
 Paralysis Amputation Contracture

IMPAIRMENTS
 Mentality Hearing Vision
 Speech Sensation

INCONTINENCE
 Bladder Bowel Saliva

ACTIVITY TOLERANCE LIMITATIONS
 None Moderate Severe

DEVICES/APPLIANCES
 Appliance Catheter Colostomy
 Cane Crutches Prosthesis
 Walker Chair, Type _____
 Wheelchair Geri Chair Side Rails
 Motorized Wheelchair/Scooter
 Special Mattress, Type _____
 Special Cushion, Type _____

DIET
 Regular Low Salt Diabetic
 Bland Low Residue
 Tube Feeding Mechanical

Describe items checked in functional information and explain necessary details of care, diagnosis, medication, treatments, prognosis, teaching, habits, preferences, etc.

MENTAL STATUS

	ALL THE TIME	FREQUENTLY	OCCASIONALLY	NEVER
Alert				
Forgetful				
Confused				

It is expected that the patient's condition within the next 6 months will:
 Improve Remain Static Deteriorate

BEHAVIOR

	ALL THE TIME	FREQUENTLY	OCCASIONALLY	NEVER
Withdrawn				
Belligerent				
Suspicious				
Combative				
Noisy				
May Wander				

Rehabilitation potential: Is the recipient at his maximum level of functioning?
 If not, what improvements are expected in his functional capacity and self-care ability?
 (a) Level of function to be attained _____
 (b) Length of time it is expected to take to arrive at this _____

SKIN CONDITION

Diminished skin integrity (include redness).
 Describe location, size, and treatment.

OTHER THERAPIES/TREATMENTS

	YES	NO	INDICATE SPECIFIC ORDERS
Physical Therapy	<input type="checkbox"/>	<input type="checkbox"/>	
Occupational Therapy	<input type="checkbox"/>	<input type="checkbox"/>	
Speech Therapy	<input type="checkbox"/>	<input type="checkbox"/>	
Respiratory Aids	<input type="checkbox"/>	<input type="checkbox"/>	
Oxygen Usage	<input type="checkbox"/>	<input type="checkbox"/>	
Intermittent	<input type="checkbox"/>	<input type="checkbox"/>	
Continuous	<input type="checkbox"/>	<input type="checkbox"/>	
Concentrator	<input type="checkbox"/>	<input type="checkbox"/>	
Tanks	<input type="checkbox"/>	<input type="checkbox"/>	
Nasal Cannula	<input type="checkbox"/>	<input type="checkbox"/>	
Mask	<input type="checkbox"/>	<input type="checkbox"/>	
Liter Flow	<input type="checkbox"/>	<input type="checkbox"/>	
Dressing Changes	<input type="checkbox"/>	<input type="checkbox"/>	

NAME OF EXAMINING PHYSICIAN (PLEASE PRINT)		DATE
SIGNATURE OF PERSON COMPLETING FORM		TITLE OF PERSON COMPLETING FORM
ADDRESS		TELEPHONE NUMBER ()