

**DEPARTMENT OF VETERANS AFFAIRS
VA BOSTON HEALTHCARE SYSTEM
RESPITE CARE APPLICATION**

PATIENT'S NAME: _____

(LAST, FIRST)

Non-SC _____ SC _____ % SERVICE CONNECTED (SC) FOR: _____

ADDRESS: _____

TELEPHONE #: () _____ DATE OF BIRTH: _____ SS# _____

MARITAL STATUS: _____ MARITAL HISTORY (years): _____

EDUCATION: _____ HOBBIES/ INTERESTS: _____

ADVANCE DIRECTIVES/LIVING WILL: (***BRING IN COPIES) _____

ALLERGIES: _____

REASON FOR RESPITE REQUEST: _____

REFERRAL SOURCE: _____ TELEPHONE #: _____

DATES REQUESTED: _____

CARETAKER PROFILE

CAREGIVER NAME: _____ AGE: _____

RELATIONSHIP: _____ OCCUPATION: _____

PHYSICAL STATUS: _____ EMOTIONAL STATUS: _____

PHONE # CARETAKER CAN BE REACHED AT WHILE PATIENT IN HOSPITAL: () _____

SIGNIFICANT OTHER/FAMILY MEMBERS: _____

PATIENT PROFILE

COMMUNICATION: ABLE _____ UNABLE _____ APHASIC (global, receptive, expressive) _____

USES WORDS, SIGNS, GESTURES: _____

MEMORY PROBLEM: YES () NO () ORIENTATION: ALERT & ORIENTED X1 _____ X2 _____ X3 _____ X4 _____

TENDENCY TO WANDER: YES () NO () DESCRIBE _____

ASSAULTIVE: YES () NO () DESCRIBE _____

TENDENCY TO FALL: YES () NO () DATE / TIME OF LAST FALL? _____

HOW DID FALL HAPPEN? DESCRIBE _____

EXAMPLE: FELL ATTEMPTING TO GET OUR OF CHAIR/BED? _____

ANY INJURIES FROM THE FALL? YES () NO DESCRIBE _____

OTHER BEHAVIORS: _____

MEDICAL INFORMATION

PRIMARY CARE PHYSICIAN – NAME: _____ **TELEPHONE: ()** _____

ADDRESS: _____

DATE OF LAST PHYSICAL EXAMINATION: _____

PRIMARY DIAGNOSIS OF MEDICAL PROBLEMS – MOST SIGNIFICANT PROBLEMS:

_____	_____
_____	_____
_____	_____

PHYSICIANS CARING FOR PATIENT: VA() COMMUNITY() #HOSPITALIZATIONS IN PAST YEARS _____

DATE: _____ **REASON:** _____

DATE: _____ **REASON:** _____

DATE: _____ **REASON:** _____

SUPPORT SYSTEMS – VA SERVICES USED

ADHC (contract): _____ **GENERAL MEDICAL CLINIC** _____ **VA SUPPORT GROUPS/CLASSES** _____

GERIATRIC CLINIC _____ **VA COMMUNITY SERVICES** _____ **HBHC** _____ **OTHER** _____

ADHC (CSH) _____

COMMUNITY SERVICES USED

DAY CENTERS – FREQUENCY: _____ **PLACE:** _____ **HOMEMAKER FREQUENCY:** _____

MEAL PROGRAMS: _____ **HOME HEALTH AIDE:** _____

SUPPORT GROUP – TYPE: _____ **USEFULNESS:** _____ **NAME OF AGENCY:** _____

TRANSPORTATION: _____ **PHONE #: ()** _____

ANY OTHER PERTINENT INFORMATION FOR CARE OF PATIENT (special needs, concerns for follow-up, appointments scheduled): _____

VA BOSTON HEALTHCARE SYSTEM
RESPIRE CARE CONTRACT

Name: _____

I have been scheduled for Admission to Respite Care on _____.

***All admissions are between 9:00AM and 10:00 AM Brockton VA Campus Nursing Home Care Unit Building 4.

I will be discharged home on _____ no later than 2:00 p.m. on that day.

***TIME of Discharge to be scheduled on day of admission.

I have reviewed and understand the enclosed Respite Care Brochure and understand that Respite admissions are based on bed availability.

Note: Please sign this contract and send it to the Respite Care Coordinator (address below). If you have any questions about admission to the Respite Care Program, please contact

Olga Quinlan, LICSW Social Worker at 774-826-2858. Please FAX to: 774-826-2643 or Mail to:

Olga Quinlan, LICSW
Respite Care Coordinator
GEC OFFICE (181)
VA Boston Healthcare System
940 Belmont Street
Brockton, MA 02301

Client's Signature (if possible)

Date

Caregiver's Signature

Date

In case of Emergency DURING RESPITE STAY, please notify:

Name: _____

Relationship: _____

Address: _____

Phone: () _____
