Dear Examining Physician:

The West Virginia Division of Veterans Affairs as well as the West Virginia Code requires that upon application to the WV Veterans Nursing Facility the applicant be determined, by medical authority, to be disabled by disease, wounds or otherwise, and is, by reason of such disability, incapable of earning a living.

Please pay particular attention to the verification block above your signature on the Verification of Disability and Inability to Earn a Living section of this form. Failure to indicate yes or no in this block will prevent the timely admission of your patient.

Your cooperation is greatly appreciated.

PHYSICIAN'S CERTIFICATE
Valid for 90 Days prior to Admission

VETERAN _____ is requesting admission to the WVVNF:

Primary & Secondary Diagnoses (If psychiatric, please attach recent progress notes)

Primary: _____

Secondary: _____

_____

_____

_____

Height _____ Weight _____ _____ Current Normal	Pressure Ulcers ☐ Yes ☐ No If Yes, Where? _____ _____ _____	Known Allergies (list) _____ _____ _____ _____ _____

Physician's orders and current medications. List method & frequency of actual administrations. If diagnosis does not justify medications ordered, please explain.

MEDICATION	FREQUENCY	DIAGNOSIS

DIET: ☐ REGULAR ☐ DIABETIC ☐ Specify _____

PHYSICIAN'S CERTIFICATE
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Veteran's Name: _____

Has the applicant had any emergency room visits in the last 90 days? ☐ Yes ☐ No

Has the applicant had any hospital stays in the last 90 days? ☐ Yes ☐ No

IF YOU ANSWERED YES TO EITHER OF THE ABOVE, PLEASE HAVE THE MEDICAL RECORDS REGARDING THESE EVENTS FORWARDED TO THE ADMISSIONS OFFICE.

Is the applicant currently in a nursing home? ☐ Yes ☐ No

IF YOU ANSWERED YES TO THE QUESTION ABOVE, PLEASE HAVE THE NURSING HOME FORWARD THE MDS (MINIMUM DATA SET), PAST 30 DAYS OF NURSES AND PHYSICIAN'S NOTES, PT OR OT NOTES (IF APPLICABLE), TB TEST RESULTS, PASARR REVIEW RESULTS.

Has the applicant had any falls in the last 180 days? ☐ Yes – if yes, how many _____ ☐ No

SELF CARE STATUS		INDEPENDENT	NEEDS ASSISTANCE	UNABLE TO DO
PERSONAL HYGIENE	BATHING	☐	☐	☐
	SHAVING	☐	☐	☐
	ORAL HYGIENE	☐	☐	☐
DRESSING	UPPER EXTREMITIES	☐	☐	☐
	TRUNK	☐	☐	☐
	LOWER EXTREMITIES	☐	☐	☐
FEEDING		☐	☐	☐
ACTIVITIES OF DAILY LIVING	KEEP ROOM CLEAN	☐	☐	☐
	DO OWN LAUNDRY	☐	☐	☐
	HANDLE OWN FUNDS	☐	☐	☐
	TAKE OWN MEDS	☐	☐	☐
	WALK ONE BLOCK	☐	☐	☐
	TO AND FROM MEALS			
MOBILITY	SITTING	☐	☐	☐
	STANDING	☐	☐	☐
	TRANSFERRING	☐	☐	☐
	WALKING	☐	☐	☐
	STAIRS	☐	☐	☐
(Check Items Used)	WHEELCHAIR	☐ YES	☐ NO	
	ELEC. WHEELCHAIR	☐ YES	☐ NO	
	GERICHAIR	☐ YES	☐ NO	
	ELECTRIC SCOOTER	☐ YES	☐ NO	
	CANE	☐ YES	☐ NO	

PHYSICIAN'S CERTIFICATE Valid for 90-Days Prior to Admission	
Veteran's Name: _____	
BOWELS **BLADDER**	☐ CONTINENT ☐ INCONTINENT ☐ CONTINENT ☐ INCONTINENT
SPECIAL NEEDS	☐ CATHETER (SIZE _____) ☐ DIALYSIS ☐ COLOSTOMY (SIZE _____) ☐ C-PAP ☐ G-TUBE (SIZE _____) ☐ BI-PAP ☐ TRACHESTOMY ☐ OXYGEN
APPLIANCES	☐ PROSTHESIS ☐ DENTURES ☐ GLASSES ☐ HEARING AID ☐ OTHER _____
BEHAVIOR/ ORIENTATION	☐ ORIENTED ☐ INAPPROPRIATE OR ANTISOCIAL ☐ ANXIOUS ☐ CONFUSED/DISORIENTED ☐ FEARFUL ☐ WANDERS ☐ QUIET ☐ WITHDRAWN ☐ FRIENDLY ☐ SPECIAL PSYCHO-SOCIAL NEEDS ☐ MEMORY DEFICIT ☐ AGGRESSIVE/COMBATIVE ☐ DEPRESSED ☐ VERBALLY ABUSIVE ☐ ALCOHOL ABUSE ☐ HISTORY OF DRUG ABUSE ☐ SMOKER ☐ MENTAL ILLNESS ☐ FORGETFUL Additional comments regarding behavior_____ _____ _____
COMMUNICATION ABILITY	CAN SPEAK ☐ YES ☐ NO ENGLISH ☐ YES ☐ NO CAN WRITE ☐ YES ☐ NO UNDERSTANDS SPEAKING ☐ YES ☐ NO ENGLISH ☐ YES ☐ NO UNDERSTANDS GESTURES ☐ YES ☐ NO UNDERSTANDS WRITING ☐ YES ☐ NO

PHYSICIAN'S CERTIFICATE
Valid for 90-Days Prior to Admission

Veteran's Name: _____ Date: _____

MENTAL STATUS EXAMINATION

APPEARANCE	
ATTENTION/CONCENTRATION	
BEHAVIOR	
SPEECH	
MOOD	
PHOBIAS	
OBSESSIONS	
COMPULSIONS	
DELUSIONS	
HALLUCINATIONS	
COGNITIVE THINKING/MEMORY	

SHORT PORTABLE MENTAL STATUS QUESTIONNAIRE (SPMSQ)

QUESTION	ANSWER	CORRECT	INCORRECT
1. What is the date today?			
2. What is the day of the week?			
3. What is the name of this place?			
4. What is your street address?			
5. How old are you?			
6. When were you born?			
7. Who is the President of the US now?			
8. Who was President just before him?			
9. What was you mother's maiden name?			
10. Subtract 3 from 20 and keep subtracting 3 from each new number all the way down.			
		TOTAL NUMBER OF ERRORS	

PHYSICIAN'S CERTIFICATE
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VETERAN'S NAME: _____

REVIEW OF SYSTEMS

	NORMAL	**ABNORMAL**	**COMMENT**
HEENT	☐	☐	
SKIN	☐	☐	
NECK	☐	☐	
CHEST	☐	☐	
HEART	☐	☐	
ABDOMEN	☐	☐	
GENITALIA	☐	☐	
RECTAL/PELVIC	☐	☐	
EXTREMITIES	☐	☐	
NEUROLOGICAL	☐	☐	

BP: _____ PULSE: _____

TEMP: _____ RESP: _____

VERIFICATION OF DISABILITY AND TO EARN A LIVING

By my signature entered below, it is my professional opinion that the above named veteran applicant is disabled by disease, wounds or otherwise, and is by reason of such disability incapable of earning a living.

☐ **YES** ☐ **NO**

EXAMINING PHYSICIAN
Must Sign and Date

SIGNATURE **DATE**

NAME (PRINTED)	**PHONE NO.**
	( )

FULL ADDRESS

WV VETERANS NURSING FACILITY
TUBERCULOSIS SCREENING GUIDELINES for ADMISSION

PHYSICIAN INSTRUCTIONS (check appropriate box)

Applicant has **NO HISTORY** of a positive TB Skin Test or current signs and symptoms of TB ☐ No

Applicant has a **HISTORY** of a positive TB Skin Test ☐ Yes

If **YES** complete Sections below:

_____ Recent close contact to a person with active TB
_____ Abnormal chest x-ray showing fibrotic lesions (likely to be old TB)
_____ Known or suspected HIV infection

Date converted to Positive reactor _____

Date of Most Recent Chest X-Ray	**Results of chest x-ray** – include a copy of report
Physicians statement and evaluation of applicant's TB status:	
Recommended treatment:	
Physician's Signature:	**Date:**

Note: CDC recommendation is that persons with a documented conversion and no evidence of TB on chest x-ray receive at least six (6) months of preventative therapy unless medically contraindicated.

THESE IMMUNIZATIONS ARE NOT REQUIRED FOR ADMISSIONS TO THE WV VETERANS NURSING FACILITY.

But the information is useful for the staff to have if they have been given.

	PNEUMOCOCCAL VACCINE	TETANUS or DIPTHERIA/TETANUS	INFLUENZA VACCINE	OTHER-SPECIFY
DATE – MOST RECENT				

VETERAN APPLICANT'S NAME _____