Department of Veterans Affairs

VA Geriatrics and Extended Care (GEC) Referral

1. Source of Referral

This referral is being made from? (Check one)

- 1.1 Outpatient Clinic ☐
- 1.2 Hospital < 7 days ☐
- 1.3 Hospital > 6 days ☐
- 1.4 VA Nursing Home ☐
- 1.5 Community Nursing Home ☐
- 1.6 VA Domiciliary ☐
- 1.7 HBPC ☐
- 1.8 Other (Specify) ☐

2. Living Situation

2.1 With whom does the patient live? (Check one)

- 2.1.1 Alone ☐
- 2.1.2 Spouse only ☐
- 2.1.3 Spouse with others ☐
- 2.1.4 Child (not spouse) ☐
- 2.1.5 Others (not spouse or children) ☐
- 2.1.6 Group setting with non-relatives ☐
- 2.1.7 Other (Specify) ☐

2.2 Where does the patient live? (Check one)

- 2.2.1 Private home/Apartment ☐
- 2.2.2 Board and Care/Assisted Living ☐
- 2.2.3 Nursing Home ☐
- 2.2.4 Domiciliary ☐
- 2.2.5 Homeless ☐
- 2.2.6 Homeless shelter ☐
- 2.2.7 Other (Specify) ☐

3. Primary Caregiver Information

Primary (unpaid) Caregiver The person (unpaid) who provides most support for patient, need not be a relative. Do NOT include any paid caregivers here

3.1 ☐ No caregiver
Check no caregiver only if there is no one on whom the patient relies on for any type of support. Do not check if there is ANY person who provides ANY type of support

3.2 Last name | 3.3 First name

3.4 Street Address

3.5 City | 3.6 State | 3.7 ZIP

3.8 Telephone number with area code

3.9 Caregiver's relationship to patient? (Check one)
Spouse ☐ Child or child-in-law ☐
Other relative ☐ Friend/neighbor ☐

3.10 Support provided by informal caregiver (Check all that apply)
Advice/emotional support ☐ ADL help ☐ IADL help ☐

	YES	NO
3.11 Caregiver lives with patient?	☐	☐
3.12 Caregiver accessible to patient? Lives close enough to see pt. and provide care regularly.	☐	☐
3.13 Caregiver willing/able to increase help? Ask caregiver if s/he is willing, use your own judgment about his/her ability to increase help. Code NO if the caregiver is unwilling or, if in your judgment, is unable.	☐	☐

4. Language

(Check any language the patient speaks and understands)

4.1 English ☐ Spanish ☐ Other (specify)

5. Homebound Status

	YES	NO
5.1 Is the patient homebound (able to leave the home only infrequently and for short periods of time)?	☐	☐

6. Instrumental Activities of Daily Living

In the last 7 days, has the patient expressed **difficulty** with the following activities?
*Consider how **difficult** it **is** or **would have been** for the patient to perform these IADL activities on his/her own in the last seven days. **If you have not seen the patient perform these tasks, you must use your judgment.***

	Last 7 Days YES	Last 7 Days NO
6.1 Preparing Meals (planning, cooking, setting out food and utensils) *Answer YES if patient does NOT prepare meals, even if s/he could.*	☐	☐
6.1.1 Were meals prepared by others?	☐	☐
6.2 Housework (e.g., dishes, dusting, laundry)	☐	☐
6.3 Shopping (selecting items, managing money)	☐	☐
6.4 Transportation (getting to places beyond walking distance-any mode)	☐	☐
6.5 Using the phone (receiving or making calls - may use assistive devices)	☐	☐
6.6 Managing medications (remembering to take meds, refill meds, opening bottles, correct dosages, etc)	☐	☐
6.7 Managing own finances (maintaining a checkbook, paying own routine bills, etc.)	☐	☐
6.8 Do any of the answers above (6.1 - 6.7) indicate recent (e.g., 2-3 mo) change in functioning?	☐	☐

7. Services in the Home

Code NO if patient has been in hospital, nursing home or out of the home for the time period of the question.

	YES	NO
7.1 In the last 14 days, has the patient received assistance from a home health aide in the home?	☐	☐
7.2 In the last 14 days, has the patient received assistance from a social worker in the home?	☐	☐
7.3 In the last 30 days has the patient received help in the home from an RN? OR is an RN scheduled or authorized to make home visits in the next 30 days?	☐	☐

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8. Additional Information	YES	NO
8.1 In the last **90** days, has the patient moved in with others or have others moved in with the patient?	☐	☐
8.2 Are there any hazards or other factors that make it difficult for the patient to enter or leave the home? Any environmental factor e. g., environmental factors such as stairs, broken elevators, etc., that make it difficult to leave the home (do not count poor lighting or loose rugs/carpet)	☐	☐
8.3 Does the patient or primary caregiver believe the patient would be better off in another living environment?	☐	☐

8.4 In the last 7 days, did the patient engage in 2 or more hours of physical activity, e.g., walking, cleaning the house or exercising?	☐ ☐	**YES,** Performed for **2** or more hours **NO**, not performed or less than **2** hours
8.5 In the last 7 days, has the patient been left alone in the mornings or afternoons?	☐ ☐	**YES,** Occasionally alone, even if only for an hour **NO,** Never or hardly ever

8.6 Does the veteran have a substitute (surrogate) decision-maker designated? (Check any that apply, include names when available)

☐ Guardian _____ Durable Power of Attorney ☐ Health Care _____

☐ Fiduciary/Conservator _____ ☐ Financial _____

8.7 Has the patient completed an Advance Directive? YES ☐ NO ☐ (If yes, please place copy in Medical Record or send with patient)

9. Skilled Care

Will the patient require these treatments after referral?	YES
9.1 CPAP/BiPap or Ventilator	☐
9.2 Oxygen	☐
9.3 Suctioning	☐
9.4 Tracheostomy Care	☐
9.5 Ostomy Care (other than tracheostomy)	☐
9.6 Dysphagia Diet	☐
9.7 Tube Feeding (any method)	☐
9.8 Parenteral Feeding	☐
9.9 IV Infusions	☐
9.10 Medications by Injection	☐
9.11 Urinary Catheter Care	☐
9.12 Dialysis - Center- based	☐
9.13 Dialysis - Home -based	☐
9.14 Wound Care (other than pressure ulcer)	☐
9.15 Pressure Ulcer Care	☐

9.16 Check the stage of the **worst** pressure ulcer
1 ☐ 2 ☐ 3 ☐ 4 ☐

9.17 Frequent Nurse Observation (more than 1/ week)	☐
9.18 Physical, Speech, Occupational or Kinesiotherapy	☐
9.19 Alcohol, Drug, or other substance abuse treatment	☐

9.20 Other *(specify)* _____

10. Basic Activities of Daily Living

Code YES if the patient had ANY difficulty, required cueing or supervision, or DID NOT do the task in the last 7 days

In the last 7 days, has the patient required **help OR supervision** to perform any of the following activities**?**	Last 7 Days YES	NO
10.1 Bathing (tub bath, shower, or sponge)	☐	☐
10.1.1 Did the patient require physical assistance with bathing?	☐	☐
10.2 Dressing (lower and upper body)	☐	☐
10.3 Eating (taking in food by any method, including tube feedings)	☐	☐
10.4 Using the toilet (using toilet, urinal, bedpan-getting on and off, cleaning self, managing devices used and adjusting clothes)	☐	☐
10.5 Moving around in bed (moving to and from lying position, turning side to side, repositioning)	☐	☐
10.6 Transfers (moving to/from bed, chair, wheelchair, standing)	☐	☐
10.7 Moving around indoors (Answer yes even if with cane, walker, or scooter - Answer NO if uses wheelchair OR did not get around	☐	☐
10.8 If uses wheelchair, moving around chair (propelling and maneuvering) *Code YES if the patient can maneuver wheelchair by him/herself (even if it is a power chair)*	☐	☐
10.9 Do any of the answers above (10-1 - 10-7) indicate a recent (2-3 mos) change in functioning? *Code yes if the patient's function has significantly changed in the recent past*	YES ☐	NO ☐

11. CONTINENCE	YES	NO
11.1 Is the patient incontinent of urine?	☐	☐
11.2 Is the patient incontinent of stool?	☐	☐

12. SKIN	YES	NO
12.1 Has the patient experienced any troubling skin problems like burns, bruises, or itching in the last 30 days?	☐	☐

Additional comments pertinent to this page have been added _____

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13. Patient Behaviors and Symptoms

In the last **7** days, has the patient exhibited any of the following?	Last 7 Days YES	NO
I3.1 Wandering (moved with no rational purpose, seemingly oblivious to needs or safety)? *Wandering is purposeless movement often without regard to safety. Pacing up and down is NOT wandering.*	☐	☐
I3.2 Verbally abusive behaviors (threatened, screamed at, or cursed at others)? *Code if any such behavior occurred, regardless of patient's intent.*	☐	☐
I3.3 Physically abusive behaviors (hit, shoved, scratched or sexually abused others)? *Code if any such behavior occurred, regardless of patient's intent.*	☐	☐
I3.4 Resisting care (resisted taking medications /injections, ADL assistance, eating, or changes in position)?	☐	☐
I3.5 Hallucinations or delusions? *Hallucinations are **sensory** (auditory, visual, olfactory, tactile) experiences that are NOT real Delusions are **ideas or beliefs** that are held even though there is no evidence to support them or evidence that shows them to be false*.	☐	☐

14. Cognitive Status

14.1 In the last 7 days was the patient able, **without difficulty**, to make decisions that are reasonable about organizing the day, such as when to get up, what meals to have or what clothes to wear?	☐	**YES,** Patient consistently made reasonable decisions **without difficulty**
	☐	**NO**, Patient made decisions **with difficulty** OR did not make decisions OR decisions were poor
I4.2 In the last 7 days, has the patient usually been able to make him/herself understood?	☐	**YES,** Patient's expression of information is understood, even if s/he has difficulty in finding words or finishing thoughts
	☐	**NO**, Patient's expression of information is never (or rarely) understood OR s/he is limited to making concrete requests

	YES	NO
I4.3 In the last 90 days has the person become so agitated or disoriented that his safety was endangered or s/he required protection by others as a result?	☐	☐

15. Prognosis

	YES	NO
I5.1 In the last 7 days, has the person experienced a flare up of a recurrent or chronic health problem?	☐	☐
I5.2 Does the direct care staff (MD, rehab therapist) think the patient is capable of increased independence (in ADLs, IADLs, or mobility)?	☐	☐
I5.3 Does the patient have a limited life expectancy (likely to be less than 6 months)?	☐	☐

16. Weight Bearing

I6.1 What is the patient's weight bearing status? Full ☐ Partial ☐ None ☐

17. Diet

I7.1 Diet Regular ☐ Modified (Specify diet) _____

18. What equipment does the patient need? (Please place prosthetics requests)

18.1 Hospital Bed	☐	18.3 Trapeze	☐	18.5 Cane	☐	18.7 ADL equipment	☐	18.9 Other (specify)
18.2 Special mattress	☐	18.4 Walker	☐	18.6 Wheelchair	☐	18.8 Orthotic or splint	☐	

19. What supplies does the patient need? (Please place orders for supplies)

19.1 Catheters	☐	19.3 Dressings	☐	19.5 Tape	☐	19.7 Ostomy supplies	☐	19.9 Other (specify)
19.2 Tubing	☐	19.4 Wrappings	☐	19.6 Glucose strips	☐	19.8 Saline	☐	

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20. Goals of Care (check all that apply)

20.1 Rehabilitation (improved function)	☐
20.2 Skilled nursing care (e.g., manage wounds, medical devices, catheters, ostomy)	☐
20.3 Monitoring/supervision to avoid clinical complications	☐
20.4 Improve compliance with medications/ treatments	☐
20.5 Patient/Family Education	☐
20.6 Respite (temporary relief for caregiver)	☐
20.7 Palliative/End of Life Care	☐
20.8 Reduce hospitalizations and/or ER visits	☐
20.9 Supervised/supportive living situation	☐
20.10 Behavior Stabilization	☐

21. Referring to which program? (Check all that apply)

21.1 Skilled care in home	☐	21.10 Long-term nursing home care	☐
21.2 Home Based Primary Care (HBPC)	☐	21.11 Outpatient Respite care	☐
21.3 ADL assistance (personal care) in home	☐	21.12 Inpatient Respite care	☐
21.4 Chore Services (homemaker) in home	☐	21.13 Specialized Dementia or Geropsych Care	☐
21.5 Adult Day Health Care	☐	21.14 Inpatient palliative/hospice care (in NHCU)	☐
21.6 Residential care (supervised living)	☐	21.15 Outpatient Palliative/ hospice care (in home)	☐
21.7 Assisted Living	☐	21.16 All inclusive care or PACE program	☐
21.8 Domiciliary care	☐	21.17 Other (specify)	
21.9 Short-term nursing home care (subacute care, rehab, etc)	☐		

22. Estimated Duration of Care

22.1 1 week ☐ 22.2 2-3 weeks ☐ 22.3 One month ☐ 22.4 2-3 months ☐ 22.5 4-6 months ☐ 22.6 Indefinite ☐

Comments. (Any additional information that may be helpful to the referral program)

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This Section for Administrative Use Only **Use This Section Referral is processing (Check all that apply)**

23. Where was the patient referred?

Home Care	Funding Sources for Home Care	Structured Living Situation	Funding Sources for Structured Living Situation
Community Skilled Home Health Care ☐	VA ☐	Personal Care Home ☐	VA ☐
VA Home-Based Primary Care ☐	Medicare ☐	Community Residential Care ☐	Medicare ☐
Homemaker/Home Health Aide ☐	Medicaid ☐	Assisted Living ☐	Medicaid ☐
VA Bowel and Bladder ☐	Other insurance ☐		Other insurance ☐
Adult Day Health Care ☐	Private Pay ☐		Private Pay ☐
VA In-home Respite ☐	Other (specify)		Other (specify)

Domiciliary	Funding Sources for Domiciliary	Nursing Home Care	Funding Sources for Nursing Home Care
VA Domiciliary ☐	VA ☐	VA NHCU (Rehab) ☐	VA ☐
State Home Domiciliary ☐	Medicare ☐	VA NHCU (Long-term care) ☐	Medicare ☐
	Medicaid ☐	VA NHCU (subacute care) ☐	Medicaid ☐
	Other insurance ☐	VA NHCU (respite) ☐	Other insurance ☐
	Private Pay ☐	Community nursing home ☐	Private Pay ☐
	Other (specify)	State Veterans nursing home ☐	Other (specify)
		VA NHCU (Hospice) ☐	

Hospice Care	Funding Sources for Hospice Care	Geriatric Services	Funding Sources for Geriatric Services
VA NHCU (Hospice) ☐	VA ☐	GEM Clinic ☐	VA ☐
VA Outpatient hospice ☐	Medicare ☐	Geriatric Primary Care Clinics ☐	Medicare ☐
Community hospice ☐	Medicaid ☐	VA GEM inpatient unit ☐	Medicaid ☐
	Other insurance ☐		Other insurance ☐
	Private Pay ☐		Private Pay ☐
	Other (specify)		Other (specify)

Care Coordination/Home Telehealth	Funding Sources for Care Coordination/ Home Telehealth	OTHER (specify)	Funding Sources for OtherServices
Care Coordination/Home Telehealth ☐	VA ☐		VA ☐
	Medicare ☐		Medicare ☐
	Medicaid ☐		Medicaid ☐
	Other insurance ☐		Other insurance ☐
	Private Pay ☐		Private Pay ☐
	Other (specify)		Other (specify)

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