Department of Veterans Affairs

MILITARY TREATMENT FACILITY REFERRAL FORM TO VA LIAISON

MTF Case Manager/Social Worker: Please complete this form in its entirety, as all information is needed to register a patient with the Veterans Health Administration. Once complete, please return it to the VA Liaison for Health Care at your MTF. If there is not a VA Liaison assigned to your facility, please forward this form directly to the OEF/OIF Program Manager at the requested VA Health Care Facility.

Military Treatment Facility	Date of Referral

MTF Referral Source	Phone Number	Cell/Pager Number
Military Social Worker/Case Manager (If different than referral source)	Phone Number	Cell/Pager Number
VA Liaison for Health Care	Phone Number	Cell/Pager Number

PATIENT PERSONAL INFORMATION

Last Name	First Name	Middle Name	Suffix

Full SSN	Home Phone Number	Cell Phone Number

Complete Home Address (City & State & Zip)

County	Email Address	DOB	Mother's Maiden Name

Age	Religion	Marital Status	Place of Birth (City&State&Zip)

Gender ☐ Male ☐ Female

Is the patient Spanish, Hispanic, or Latino? ☐ Yes ☐ No

What is Patient's Race? (You may check more than one.)
(Information is required for statistical purposes only.)

☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander
☐ Asian ☐ White ☐ Black or African American

Father's Name	Mother's Name

EMERGENCY CONTACT

☐ Next-of-Kin ☐ Family ☐ Durable Power of Attorney for Health Care

Name	Relationship

Complete Address & City & State & Zip

Home Phone Number	Cell Phone Number	Does the Patient have an Advance Directive?
		☐ Yes ☐ No

PATIENT MILITARY INFORMATION: *(complete details in these responses aid in the planning of long term veterans benefits)*

Branch of Military ☐ Army ☐ Air Force ☐ Navy ☐ Marine Corps ☐ Coast Guard Rank _____

Component ☐ National Guard ☐ Reserve ☐ Active ☐ OIF ☐ OEF ☐ N/A (non-OIF/OEF)

Service Status: ☐ Active Duty (currently) ☐ Retired - Date of retirement ☐ TDRL ☐ PDRL

Service Entry Date	ETS	Release from Active Duty

Combat Dates & Theater (locations)

Parent Command & POC & Phone Number

☐ In process of discharge: ☐ ETS ☐ MEB ☐ Limited Duty ☐ Admin Sep ☐ Other:

Anticipated date of separation (if known):

Status of MEB/PEB:

Patient's Last Name:	Patient's SSN:

MTF HEALTH CARE TREATMENT AND PLAN

Date of injury:	☐ BI ☐ NBI ☐ Disease/ Disorder

INJURY/COMBAT RELATED INJURY/DIAGNOSIS DETAILS:

DISCHARGE PLAN from Military Treatment Facility [to include WHEN and WHERE patient will be d/c & discharge status, i.e. TDRL, convalescent leave pending medical d/c, convalescent leave pending return to duty, Con Lv pending return to MTF, etc]:

1) What is the estimated departure date from MTF or arrival date home? (so VHA can arrange follow-up care):

2) Has MTF Case Manager requested a TriCare /MMSO authorization? ☐ YES ☐ NO	If so when was clinical order entered?

3) Name of Attending Physician and Contact Number(s):

4) Name of Nurse/Nurses' Station Ward and Contact Number(s):

REQUEST FOR VA HEALTH CARE, Must be Completed by a MTF Health Care Clinician (i.e. Case Manager/SW/MD)

Requested VA Health Care Facility:

Is patient a VA Employee	☐ *YES* ☐ *NO*

REQUESTED HEALTH CARE: *please check all that apply, and provide corresponding medical records.*

INPATIENT CARE

- ☐ Traumatic Brain Injury
- ☐ Spinal Cord Injury
- ☐ Mental Health (Psychiatry, PTSD, Substance Abuse)
- ☐ Blind Rehabilitation
- ☐ Long-term care/Nursing Home
- ☐ Other:

OUTPATIENT CARE

- ☐ Primary Care:
- ☐ Mental Health (Psychiatry, Psychology, PTSD, Substance Abuse):
- ☐ Therapy (PT, OT, Speech):
- ☐ Pain Management:
- ☐ Visually Impaired Services:
- ☐ Durable Medical Equipment/Prosthetics:
- ☐ Specialty Clinics (Neuro, Ortho, Cardiology, ENT, wound care, suture removal, Audiology):
- ☐ TBI/Polytrama:
- ☐ Other:

Please indicate the plan for the transfer of Medical Records:

NOTE: At the time of the patient transfer the discharge summary and current discharge medication list will need to be included.
(if referring to an inpatient setting (i.e. Polytrauma Center, TBI, SCI), or if clinically indicated (i.e. ortho, surgery) please request a CD of patient's films)

Patient's Last Name:	Patient's SSN:

[As appropriate:]	REFERRALS TO POLYTRAUMA WILL NEED TO INCLUDE THE FOLLOWING:
☐	History & Physical
☐	Notes from theater,Germany, Medivac flight note, etc.
☐	MD progress notes. If pt has fractures include ortho note w/ weight bearing status & any other restrictions.
☐	Include notes from Specialty Services i.e. neurosurgery, neurology, ID, plastics, ophthalmology
☐	Current lab work: CBC, comprehensive metabolic panel, urinalysis, and others as appropriate (i.e. INR, arterial blood gases, etc)
☐	Cumulative microbiology results
☐	Cumulative results of cerebrospinal and any other fluid analysis (i.e. pleural, ascitic, synovial, etc.)
☐	Current medications
☐	Radiology reports for CT scans, MRI's, ultrasounds, vascular studies, special procedures, angiograms & list of radiology studies performed
☐	OR notes (especially regarding all implanted devices such as pegs, trachs, stents, filters, etc.)
☐	Recent therapy notes from OT, PT, & SLP
☐	Neuropsychology testing performed
☐	Social Work psychosocial assessment
☐	Interim summary describing the hospital course and complications to date

Patient's Last Name:	Patient's SSN: