

**HEALTH QUESTIONNAIRE
DEPARTMENT OF VETERANS' AFFAIRS
ILLINOIS VETERANS' HOMES**

APPLICATION WILL NOT BE REVIEWED UNLESS THIS FORM IS COMPLETED AND A COPY OF THE
LAST OR MOST RECENT HISTORY AND PHYSICAL OR DISCHARGE SUMMARY IS ATTACHED.
(TO BE COMPLETED BY LICENSED PHYSICIAN)

APPLICANT NAME: _____ DATE: _____

Current residence: Acute hospital _____ Nursing home _____ Home _____

Name, Address and Phone Number of Hospital or Nursing Home

If at home, number of inhabitants _____

CURRENT DIAGNOSIS(SES):

Present medications taken (Type, strength, dosage)

PLEASE CHECK EACH OF THE FOLLOWING:

(Space provided on page 4 for additional comments or attach additional sheets.)

	YES	NO	PARTIALLY
1. <u>Can applicant do the following:</u>			
a. Dress and use lavatory?	_____	_____	_____
b. Bathe?	_____	_____	_____
c. Oral hygiene?	_____	_____	_____
d. Reposition in bed?	_____	_____	_____
e. Ascend and descend steps?	_____	_____	_____
f. Feed self?	_____	_____	_____
g. Operate wheelchair, if needed, without aid?	_____	_____	_____

- | | YES | NO | PARTIALLY |
|-------------------------------|-------|-------|-----------|
| 2. Is applicant: | | | |
| a. Aphasic? | _____ | _____ | _____ |
| b. Deaf?..... | _____ | _____ | _____ |
| c. Blind? | _____ | _____ | _____ |
| d. Cardiac Patient?..... | _____ | _____ | _____ |
| e. Using oxygen? | _____ | _____ | _____ |
| f. Continent of bowel?..... | _____ | _____ | _____ |
| g. Continent of bladder?..... | _____ | _____ | _____ |
| h. Mentally competent? | _____ | _____ | _____ |
| i. Able to walk 1 block?..... | _____ | _____ | _____ |

3. Does applicant require sensory aid? _____ Specify: _____

	YES	NO
4. Does applicant have decubiti (bedsores)?	_____	_____
If yes, describe: _____		

5. ** Is any infection present?

** Is there a history of MRSA, VRE or any other anti-biotic resistant infection?

6. ** Is applicant undergoing Cancer/Dialysis treatment?.....

** Is there a past history of Cancer/Dialysis?.....

7. ** Is applicant ambulatory without assistance?.....

a. Require crutches, walker, wheelchair?.....

b. Require complete bed care?

8. ** ...Does applicant require prosthesis?.....

** If answer to questions 5, 6, 7, or 8 is YES, please give brief explanation:

	YES	NO
9. Is applicant mentally capable of managing personal needs or self-administering oral medications without supervision? (Explain on page 4).....	_____	_____

10. **Does applicant have a history of: (Explain YES answers on page 4)**

a. Alcoholism? (Treatment program; see #15)	_____	_____
b. Epilepsy?	_____	_____
c. Dyspnea?	_____	_____
d. Psychiatric treatment? (When, where; see #15).	_____	_____
e. Chemical abuse? (Include prescription meds).....	_____	_____
f. Depression?	_____	_____
g. Verbally combative? (Give examples on Page 4).....	_____	_____
h. Physically combative? (Give examples on Page 4)	_____	_____

11. **Does applicant require:**
- a. Observation to make his/her wants known? _____
 - b. Spoon-feeding? _____
 - c. Tube feeding? _____
 - d. Tracheostomy suctioning? _____
 - e. Colostomy / Urostomy care? _____
 - f. Special Diet? Specify: _____
 - g. Appetite? Specify: _____
 - h. Is applicant a cigarette smoker? _____
Use of other tobacco products? Specify: _____
 - i. Does applicant have Foley catheter?..... _____

12. Will applicant require supervision to prevent wandering from assigned unit? If YES, please give a brief explanation:

13. Most recent date applicant had the following vaccine/tests:

Pneumonia _____

Influenza _____

Tetanus/Diphtheria (DT) _____

Mantoux . . . If **positive** - Millimeter of Induration _____

Treatment received: _____

14. Has applicant been hospitalized or received outpatient treatment for any of the following reasons?

	Hospital	City	Date
Psychiatric treatment	_____		
Surgery	_____		
Alcohol/Substance Abuse	_____		

Please give brief explanation:

NOTICE TO EXAMINING PHYSICIAN - History, symptoms and physical findings must be recorded in sufficient detail to clearly support the diagnoses. Include recent history or current diagnosis of infectious disease with pertinent pathology information.

PUBLIC ACT 90-366 REQUIRES THAT BEFORE A PROSPECTIVE RESIDENT'S ADMISSION TO A FACILITY, THE FACILITY SHALL ADVISE THE PROSPECTIVE RESIDENT TO CONSULT A PHYSICIAN TO DETERMINE WHETHER THE PROSPECTIVE RESIDENT SHOULD OBTAIN A VACCINATION AGAINST PNEUMOCOCCAL PNEUMONIA.

PLEASE ADD COPIES OF PATIENT'S LAST HOSPITALIZATION (H & P) OR MOST RECENT DISCHARGE SUMMARY AND MOST RECENT NINETY DAYS OF NURSING NOTES IF CURRENTLY IN A NURSING HOME

- - - - -

ADDITIONAL COMMENTS
(Please attach additional sheets if necessary)

- - - - -

Based on the applicant's current medical status, placement for nursing home care is appropriate.

YES _____ NO _____

Signed: _____
Examining Physician

Address: _____

Date: _____

City, State
Zip Code _____

Name: _____
Printed / Typed

Phone: (_____) _____
Area Code Phone Number

IMPORTANT NOTICE: This State Agency is requesting disclosure of information necessary to accomplish the statutory purposes of ILCS Chapter 20, Act 2805. Inasmuch as this information is VOLUNTARY, failure to provide it may prevent admission to the Veterans Home. This form has been approved by the Forms Management Center.

APPLICATION WILL NOT BE REVIEWED UNLESS THIS FORM IS COMPLETED AND A COPY OF THE LAST OR MOST RECENT HISTORY AND PHYSICAL OR DISCHARGE SUMMARY IS ATTACHED.