



MEDICAL CARE DETERMINATION For Admission to Wisconsin Veterans Home

WVH-Chippewa Falls
2175 E. Park Ave.
Chippewa Falls, WI 54729
(715) 258-4252

WVH-King
N2665 County Rd. QQ
King, WI 54946-0600
(715) 258-5586 Fax (715) 256-3207

WVH-Union Grove
21425 G Spring St.
Union Grove, WI 53182
(262) 878-6702 Fax (262) 878-6778

Our ability to determine if we can adequately care for an individual is dependent on the information in this application. Please complete it as thoroughly as possible to ensure the application process is not delayed.

SECTION 1: To be completed by applicant, family or caregiver.

Applicant's Name: _____ Date of Birth: _____

Applicant's Address: _____

Applicant's Phone #: _____

At the time of Application Resides at: Own Home Assisted Living Nursing Home Hospital

A member of our nursing staff will be calling to gather further information to determine whether our nursing staff will be able to care for the applicant. Please indicate the caregiver who could give the most accurate information regarding the applicant's hygiene practices and preferences, eating abilities, dressing abilities, ambulation abilities, etc. Please provide the name of the person to contact, address, phone number **if other than the applicant**.

Caregiver's Name: _____

Relationship: Check the most appropriate.

- Relative Home health staff Assisted living staff Other: _____
- Caregiver Hospital staff Nursing home staff

Address: _____

Home Phone #: _____ Work Phone #: _____

The best time and place to contact this person between the hours of 8AM to 6PM

SECTION 2: To be completed by the Applicant's Physician

Please complete legibly. Please send any available medical records and diagnostic studies with application.

List of physicians, hospitals, and/or other health care facilities where medical records can be obtained. (Please have the applicant sign a release form allowing us to receive those records and send the records to the Wisconsin Veterans Home.)

Name	Address

Mentally incapacitated individuals may not be admitted to a **nursing home** unless: 1) they have **previously** executed a Power of Attorney for Health Care while competent which gives the health care agent the authority to admit the individual to a nursing home, or 2) the individual is protected by guardianship and protectively placed. No **residential care apartment** complex may admit any of the following persons, unless the person being admitted shares an apartment with a competent spouse or other person who has legal responsibility for the individual: 1) a person who has a court determination of incompetence and is subject to a guardianship, 2) a person who has an activated power of attorney for health care, 3) a person who has been found by a physician or psychologist to be incapable of recognizing danger, summoning assistance, expressing need or making care decisions.

1. Is applicant permanently incapacitated and unable to engage in any substantially gainful employment due to physical disability or age? Yes No
2. Does the applicant express adequate understanding and comprehension of his medical problems? Yes No
3. Does the applicant independently make informed decisions regarding medical care? Yes No
4. Does applicant exhibit wandering at this time? Yes No
5. If "Yes" is checked for A, B, or C, please submit a summary of both past and present treatments the applicant has received. If "Yes" is checked for C, list the specific diagnosis:
 - A. Chronic Alcoholism Yes No Active Remission
 - B. Drug Addiction Yes No Active Remission
 - C. Psychosis Yes No Active Remission

Communicable Disease:

A physician must certify that an individual is free of clinically apparent communicable disease including tuberculosis prior to nursing home admission (HFS-132.52).

1. **Any evidence or symptoms of active infectious Tuberculosis? (This question MUST be answered or the application will be considered incomplete and returned.)** Yes No
2. Date of last PPD/skin test: _____ Describe result: (induration in mm, positive, negative)
3. Date of last chest x-ray: _____ Radiologist reading: _____
4. Does the applicant have a current diagnosis of or a past history of any of the following:
 - a. Clostridium difficile: Current History Unknown
 - b. Conjunctivitis: Current History Unknown
 - c. Hepatitis (infectious): Current History Unknown
 - d. HIV infection: Current History Unknown
 - e. MRSA: Current History Unknown
 - f. Pneumonia: Current History Unknown
 - g. Respiratory infection: Current History Unknown
 - h. Septicemia: Current History Unknown
 - i. STDs: Current History Unknown
 - j. UTI last 30 days: Current History Unknown
 - k. Viral hepatitis: Current History Unknown
 - l. VRE: Current History Unknown
 - m. Wound infection: Current History Unknown

Vaccination Status:

Flu Vaccine: Type given: _____ (date last given) _____

Pneumococcal Vaccine: (date last given) _____

Tetanus / Diphtheria Booster: (date last given) _____

Pain: Describe the frequency with which the patient complains of or shows pain, the intensity of pain on a scale of 1-10, 10 being the worst, and the pain site.

Pain Site	Frequency	Intensity (1-10)	Treatment

Allergies (please list):	

Below is a list of diagnoses. Please check the ones that apply to this applicant indicating whether they are current or past history, add any others that are not listed as well as any surgical procedures. Please indicate whether it is mild (1), moderate (2), or severe (3) or submit a copy of the current diagnosis list.

Diagnosis	Severity	Current	Past History	Diagnosis	Severity	Current	Past History
Alzheimer's disease				Hypotension			
Anemia				Hypothyroidism			
Anxiety disorder				Macular degeneration			
Aphasia				Manic depression (bipolar disease)			
Arteriosclerotic heart disease				Missing limb (e.g. amputation)			
Arthritis				Multiple sclerosis			
Asthma				Osteoporosis			
Cancer				Paraplegia			
Cardiac dysrhythmias				Parkinson's disease			
Cataracts				Pathological bone fracture			
Cerebral palsy				Peripheral vascular disease			
Cerebrovascular accident				Quadriplegia			
Congestive heart failure				Renal failure			
Deep vein thrombosis				Schizophrenia			
Dementia other than Alzheimer's disease				Seizure disorder			
Depression				Transient ischemic attacks			
Diabetes mellitus				Traumatic brain injury			
Diabetic retinopathy				Other (list below):			
Emphysema / COPD							
Glaucoma							
Hemiplegia / Hemiparesis							
Hip fracture							
Hypertension							
Hyperthyroidism							

Skin: Please describe any skin problems the patient has had, past or present. For Ulcers/pressure sores, indicate the type and stage (1-4) if appropriate and the treatment. Please list any other skin problems and the treatment (i.e., abrasions, skin tears, rashes, surgical wounds, etc.). Also indicate any foot problems and treatment (i.e., nails, calluses, special shoes/inserts, etc.).

Problem	Yes	No	Description	Location	Size	Treatment
Abrasions	<input type="checkbox"/>	<input type="checkbox"/>				
Braces	<input type="checkbox"/>	<input type="checkbox"/>				
Bruises	<input type="checkbox"/>	<input type="checkbox"/>				
Burns	<input type="checkbox"/>	<input type="checkbox"/>				
Calluses	<input type="checkbox"/>	<input type="checkbox"/>				
Cuts	<input type="checkbox"/>	<input type="checkbox"/>				
Dressings	<input type="checkbox"/>	<input type="checkbox"/>				
Foot problems	<input type="checkbox"/>	<input type="checkbox"/>				
Open lesions	<input type="checkbox"/>	<input type="checkbox"/>				
Problem nails	<input type="checkbox"/>	<input type="checkbox"/>				
Rashes	<input type="checkbox"/>	<input type="checkbox"/>				
Shoe inserts	<input type="checkbox"/>	<input type="checkbox"/>				
Skin tears	<input type="checkbox"/>	<input type="checkbox"/>				
Special shoes	<input type="checkbox"/>	<input type="checkbox"/>				
Splints	<input type="checkbox"/>	<input type="checkbox"/>				
Surgical wounds	<input type="checkbox"/>	<input type="checkbox"/>				
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>				

