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 Healthcare at your MTF. If there is not a VA Liaison assigned to your facility, please forward this form directly to the Transition and Care Management Program Manager at the requested VA Health Care Facility.

Military Treatment Facility	Date of Referral

MTF Referral Source	Phone Number	Alternate Form of Contact (i.e. Cell, Email)
DoD Lead Coordinator	Phone Number	Alternate Form of Contact (i.e. Cell, Email)
VA Liaison for Healthcare	Phone Number	Alternate Form of Contact (i.e. Cell, Email)

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	Gender	Religion
	☐ Male ☐ Female	

DOB	Age	Place of Birth (City, State & Zip)

Race/Ethnicity

☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander
☐ Asian ☐ White ☐ Spanish, Hispanic, or Latino
☐ Black or African American ☐ Other

Marital Status	Number of Children / Dependents	Spouse / Partner's Name (if applicable)	Mother's Maiden Name

Mother's Name	Father'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	Alternate Form of Contact (i.e. Work, Email)

PATIENT MILITARY INFORMATION

Branch of Military	☐ Army ☐ Air Force ☐ Navy ☐ Marine Corps ☐ Coast Guard Rank: _____
Component	☐ Active Duty ☐ Reserve ☐ National Guard ☐ Other Service Entry Date: _____
Service Status	☐ Active Duty (currently) ☐ Retired - Date of retirement: _____
	☐ Non-combat ☐ OIF ☐ OEF ☐ OND ☐ Other

Combat Dates & Theater (locations)	Parent Command, POC & Phone Number

☐ IDES - Status: ☐ Complete ☐ In-process	DoD Rating %	☐ TDRL ☐ PDRL	Proposed VA Service-Connection %

☐ Administrative Separation or Chapter:	Character of Separation: ☐ HON ☐ GEN ☐ OTH ☐ DH
Separation date this period:	Projected departure date from the MTF:

Patient's Last Name:	Patient's SSN:

MTF HEALTH CARE TREATMENT AND PLAN

Ill or injured designation: ☐ Combat injury ☐ Non-combat injury ☐ Disease / Disorder

Date of injury:

INJURY / DISEASE / DISORDER DIAGNOSIS DETAILS *(Please give brief overview of medical conditions / injuries) Note: Limited to 681 characters.*

Designated as HIGH RISK: ☐ NO ☐ YES *(Please explain reason for HIGH RISK designation) Note: Limited to 207 characters.*

Medication List, Concerns and / or Issues. *Note: Limited to 207 characters.*

Medication Plan for transition period: _____ days of medication available or refills entered.

DISCHARGE PLAN from Military Treatment Facility (to include WHEN and WHERE patient will be discharged, current discharge status, i.e. convalescent or transition / terminal leave; pending medical discharge, return to duty, return to MTF, separation, etc.) *Note: Limited to 207 characters.*

Has a TRICARE / MMSO authorization been requested? ☐ NO ☐ YES If yes, when was the order entered? *Note: Limited to 103 characters.*

SOURCE OF MEDICAL INFORMATION: ☐ MTF referral source ☐ Self-Report ☐ IDES ☐ Family member / Caregiver ☐ Other

Describe Other. *Note: Limited to 112 characters.*

OUTPATIENT VA HEALTH CARE REQUESTED

Requested VA Health Care Facility:

Is patient a VA Employee ☐ NO ☐ YES Has patient been registered at VA previously? ☐ NO ☐ YES

REQUESTED HEALTH CARE (*please check all that apply, provide corresponding medical records, indicate specialties as needed, and explain duration / timeline as appropriate):*

OUTPATIENT CARE

☐ Primary Care: *Note: Limited to 207 characters.*

☐ Mental Health (Psychiatry, Psychology, PTSD, Substance Abuse): *Note: Limited to 207 characters.*

☐ Therapy (PT, OT, Speech): *Note: Limited to 207 characters.*

☐ Pain Management: *Note: Limited to 207 characters.*

☐ Visually Impaired Services: *Note: Limited to 207 characters.*

☐ TBI / Polytrama: *Note: Limited to 207 characters.*

☐ DME / Prosthetics: *Note: Limited to 207 characters.*

Patient's Last Name:	Patient's SSN:

☐ Specialty Care (Neuro, Ortho, Cardiology, ENT, Wound Care, Suture Removal, Audiology): *Note: Limited to 207 characters.*

☐ Dental: *Note: Limited to 207 characters.*

☐ Specialty Programs (Military Sexual Trauma, Suicide Prevention, Driver Evaluation): *Note: Limited to 207 characters.*

☐ Other: *Note: Limited to 207 characters.*

INPATIENT VA HEALTH CARE REQUESTED

Requested VA Health Care Facility:

Is patient a VA Employee ☐ NO ☐ YES Has patient been registered at VA previously? ☐ NO ☐ YES

REQUESTED HEALTH CARE (*please check all that apply, provide corresponding medical records, indicate specialties as needed, and explain duration / timeline as appropriate):*

INPATIENT CARE

☐ TBI: *Note: Limited to 207 characters.*

☐ Polytrauma: *Note: Limited to 207 characters.*

☐ Spinal Cord Injury: *Note: Limited to 207 characters.*

☐ Psychiatric (PTSD or Substance Abuse Recovery Program): *Note: Limited to 207 characters.*

☐ Blind Rehab: *Note: Limited to 207 characters.*

☐ Long Term Care / Nursing Home: *Note: Limited to 207 characters.*

☐ Other: *Note: Limited to 207 characters.*

FOR USE BY LIAISON

Ill or injured designation: ☐ Seriously Ill / Injured ☐ Not Seriously Ill / Injured

Notes. *Note: Limited to 6450 characters.*

Patient's Last Name:	Patient's SSN: