Department of Veterans Affairs

# VA LIAISON FOR HEALTHCARE REFERRAL FORM

This form is used to coordinate the transition into VA health care for transitioning Service members and new Veterans through a VA Liaison for Healthcare. Please complete this form in its entirety, as all information is needed to register for VA health care. Once complete, return this form to your site's VA Liaison for Healthcare, which you can locate here: https://www.va.gov/POST911VETERANS/VA_Liaison_for_Healthcare_Locator.asp

## REFERRAL DETAILS

1. DATE REFERRED TO VA LIAISON *(MM/DD/YYYY)*
2. ASSIGNED MTF
3. VA LIAISON FOR HEALTHCARE
4. MTF REFERRAL SOURCE NAME, ROLE, CONTACT INFORMATION
5. DOD LEAD COORINDATOR NAME, CONTACT INFORMATION
6. VA LIAISON RECEIVED COMPLETE REFERRAL PACKET ☐ YES ☐ NO
7. STATUS OF 1010EZ
8. STATUS OF DD214
9. REQUESTED VA FACILITY
10. TYPE OF VHA CARE REQUESTED

## DEMOGRAPHIC INFORMATION

### Patient Personal Information

11. NAME *(Last, First, Middle)*
12. FULL SSN *(999-99-9999)*
13. DATE OF BIRTH *(MM/DD/YYYY)*
14. PHONE NUMBER(S)
15. POST DISCHARGE ADDRESS
16. MAILING ADDRESS *(If different)*
17. EMAIL ADDRESS
18. SEX ☐ MALE ☐ FEMALE
19. RACE/ETHNICITY
20. MARITAL STATUS
21. NUMBER OF DEPENDENT CHILDREN
22. PLACE OF BIRTH
23. MOTHER'S MAIDEN NAME
24. RELIGION
25. EMERGENCY CONTACT NAME, RELATIONSHIP, PHONE, ADDRESS

### Patient Military Service History

26. DOD ID
27. BRANCH OF SERVICE ☐ ARMY ☐ NAVY ☐ AIR FORCE ☐ MARINE CORPS ☐ COAST GUARD ☐ SPACE FORCE
28. SERVICE COMPONENT ☐ ACTIVE ☐ RESERVE ☐ GUARD
29. SERVICE STATUS ☐ ACTIVE ☐ TITLE 10 ☐ TITLE 32 ☐ RESERVE
30. RANK
31. SERVICE ENTRY DATE *(MM/DD/YYYY)*
32. COMBAT DEPLOYMENT HISTORY

| Patient Military Discharge Information |
|---|
| 33. MILITARY DISCHARGE DATE *(MM/DD/YYYY)* |
| 34. TYPE OF DISCHARGE ☐ IDES ☐ LDES ☐ LONGEVITY RETIREMENT ☐ ETS ☐ REFRAD ☐ ADMIN SEP ☐ CHAPTER |
| 35. CHARACTER OF SERVICE |
| 36. DOD RATING *(%, PDRL, TDRL)* AND MEB REFERRED CONDITIONS *(if known)* |
| 37. VA RATING *(%, Proposed, Final)* |
| 38. EXPECTED DEPARTURE FROM THE MTF *(MM/DD/YYYY)* |
| 39. SM VERBALIZED UNDERSTANDING SM CAN/SHOULD UTILIZE TRICARE, NEAREST MTF AND/OR VET CENTER WHILE ON AD STATUS<br>☐ CONFIRMED |

| MEDICAL INFORMATION / VHA CARE REQUESTED |
|---|
| 40. HAS THE SM BEEN PLACED ON THE HIGH INTEREST LIST BY THEIR MILITARY BRANCH?<br>☐ YES *(If yes, why?)* _____<br>☐ NO |
| 41. IS THE SM DESIGNATED SERIOUSLY ILL/INJURED?<br>☐ YES *(If yes, why?)* _____<br>☐ NO |
| |
| 42. ☐ INPATIENT ☐ OUTPATIENT |
| |
| 43A. TRICARE AUTH REQUESTED? |
| 43B. DATE REQUESTED *(MM/DD/YYYY)* |
| 44. TRICARE AUTH TYPE AND NUMBER(S) |
| **VHA Care Requested** ***(Additional Details about Injury/Disease/Disorder)*** |
| 45. **PRIMARY CARE** |
| |
| 46. **MENTAL HEALTH** *(to include Suicide Prevention, Military Sexual Trauma)* |
| |
| 47. **SPECIALTY CARE** |
| |
| 48. **BIOPSYCHOSOCIAL NEEDS** *(Please include if at-risk for adverse outcomes during transition. If so, why?)* |
| |
| 49. MEDICATION |
| 50. DAYS OF MEDICATION REQUESTED FOR TRANSITION PERIOD |
| 51. DURABLE MEDICAL EQUIPMENT/PROSTHETICS |
| |
| 52. **DISCHARGE PLAN FROM THE MTF/ MILITARY INSTALLATION/ P3 SITE** *(include WHEN and WHERE the 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.)* |