MRF

MEDICAL RECORD RELEASE FORM

PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C 136, Under Secretary of Personnel and Readiness; 24 U.S.C. 401, Armed Forces Retirement Home; DoD Directive 5124.09 Assistant Secretary of Defense for Personnel and Readiness Force Management; DoD Instruction 1000.28, Armed Forces Retirement Home (AFRH); and E.O. 9397 (SSN), as amended.

PURPOSE: To determine and verify eligibility for admission to the AFRH.

ROUTINE USE(S): In addition to those disclosures generally permitted under 5 U.S.C. 552a(b) of the Privacy Act of 1974, as amended, the records contained herein may specifically be disclosed outside the DoD as a routine use pursuant to 5 U.S.C. 552a(b)(3) as follows: To the Federal Reserve for processing the debt on the resident account; To authorized contractors or vendors for the purpose of providing medical services to the residents of the Armed Forces Retirement Home; To any Federal agency which provides medical services to residents of the Armed Forces Retirement home; To the Inspector General of the Department of Defense or his/her designee, for conducting inspections of AFRH records; To a Federal agency, or an organization or person contracting with the AFRH for information needed in the performance of official duties related to reconciling or reconstructing data files, compiling descriptive statistics, and/or making analytical or financial studies to support the function for which the records were collected and maintained; Law Enforcement Routine Use; Congressional Inquiries Disclosure Routine Use; Disclosure of Information to the National Archives and Records Administration Routine Use; Disclosure to the Merit Systems Protection Board Routine Use; and Data Breach Remediation Purposes Routine Use.

The applicable system of records notice is DPR 38 DoD, Armed Forces Retirement Home electronic Resident Information System (eRIS) and is available at: (ADD LINK WHEN PUBLISHED).

DISCLOSURE: Voluntary; however, failure to provide the required information may result in the delay or denial of admission.

ARMED FORCES RETIREMENT HOME

Authorization to Release Medical Records

Form Completed by the Applicant

MRF

MEDICAL INFORMATION DISCLOSURE FORM: *SIGNATURE OF RELEASE IS **REQUIRED** FOR PROCESSING OF ANY MEDICAL FORMS*

Patient's Name:				Birthdate:	
Street:		Apt.:			
City:		State:		Zip:	
Phone:		Cell:			
Email:					(if available)

Healthcare providers: Applicants must include the examiner's **Name, Phone,** and **FAX** numbers for the healthcare professionals who completed the medical exam form and the functional assessment form.

Primary Care Provider* – Completed the Medical Exam Form (must be a licensed MD, DO, PA, or NP)

Examiner's Name :				Credentials*	
Street:		Clinic:			
City:		State:		Zip:	
Phone*:		Fax*:			
Email:		(If provided, email is only to be used for contact not submission of patient information)			

Occupational/Physical Therapist* – Completed the Functional Assessment Form (must be a licensed PT or OT)

Examiner's Name :				Credentials*	
Street:		Clinic:			
City:		State:		Zip:	
Phone*:		Fax*:			
Email:		(If provided, email is only to be used for contact not submission of patient information)			

I grant my permission to disclose information to:

☐ Armed Forces Retirement Home
3700 North Capitol Street, NW
Washington, DC 20011

Attn: Admissions Board
Public Affairs Office #584
Tel: 202-541-7922 Fax: 202-541-7519

Specific information to be disclosed:

☐ Medical Records covering the last 12 months
☐ Insurance records
☐ Records of Drug, Alcohol or Substance Use Disorders
☐ HIV/AIDS-Related Information and test results
☐ Patient history and office notes
☐ Billing records
☐ Mental Health records
☐ COVID-19 Related Information and test results

I understand that release of this information is provided on a voluntary basis in accordance with the Privacy Act Statement Authority: 10 U.S.C 136; 24 U.S.C. 401 (full version is provided on the cover page of the application) to determine and verify eligibility for admission to the Armed Forces Retirement Home. I understand that I may revoke this authorization at any time by giving written notice to AFRH at the aforementioned address. I also understand the revocation of this authorization will not affect any action taken by AFRH in reliance on this authorization prior to receipt of a written revocation. I fully acknowledge that failure to provide any required information may result in the delay or denial of admission to the Armed Forces Retirement Home.

Patient's Signature*	***Date****

Note: Signature of this release is REQUIRED for the processing of any medical forms in your application.

MRF 01-2021
Prior Versions No Longer Valid

Take this form to
Licensed Medical Provider
MD / DO / PA / NP

ME

MEDICAL EXAMINATION

If FAXING documents to AFRH, please make a black & white copy before sending the fax so that it will be legible when it is received. Please call and let us know to look for the documents to come through as well – thank you for all your help! We want to prevent any delays in processing applications!

Dear Applicant:

The Armed Forces Retirement Home requires the completion of a comprehensive Medical Examination and current Tuberculosis Screening for all applicants in order to determine eligibility for residence.

Please provide this form to a licensed medical provider **[must be a Physician (M.D. or D.O.), Nurse Practitioner (NP) or Physician's Assistant (PA)]** to complete. In order to be considered for residency, this form will need to be submitted along with the completed Application Form and Functional Assessment.

Please review the form before submitting and ensure all items have been completed and that your provider has initialed and signed in all of the appropriate fields. Incomplete forms will delay processing of the application.

Thank you
AFRH

RETURN EVALUATION TO:

ARMED FORCES RETIREMENT HOME
PUBLIC AFFAIRS OFFICE #584
3700 NORTH CAPITOL ST, NW
Washington, DC 20011-8400
Fax Number: (202) 541-7519
Telephone: (800) 422-9988 opt. 1

Last Name | First Name | MI | Birthdate

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ARMED FORCES RETIREMENT HOME

Medical Examination

ME

Last Name _____ First Name _____ MI _____ Birthdate _____

Patient: _____ Age: _____

Street: _____ DOB: _____

City: _____ State: _____ Zip: _____

Phone*: _____ Email: _____

THIS FORM IS TO BE COMPLETED BY THE APPLICANT'S LICENCED MEDICAL PROVIDER

Must be a Physician (M.D. or D.O.), Nurse Practitioner (NP), or Physician's Assistant (PA) ONLY

This examination form was completed on _____ (Date) by _____ (Printed Name of physician/nurse performing exam and credentials)

Gender	Tobacco-Use	Current Living Situation
◯ Male	◯ Smoker	◯ Lives alone → ☐ Single ☐ Separated ☐ Divorced ☐ Widowed
◯ Female	◯ Non-Smoker	◯ Lives with → ☐ Spouse ☐ Child/Family ☐ Other:

Medical History - Please indicate if the person has ANY history of the following conditions

Yes	No	Condition (MARK ALL Y/N)	Yes	No	Condition (MARK ALL Y/N)	Yes	No	Condition (MARK ALL Y/N)
☐	☐	Coronavirus (COVID-19)	☐	☐	Medical Hospitalizations (5yrs)	☐	☐	Vision Loss / Legally Blind / Glaucoma
☐	☐	Anticoagulation Therapy	☐	☐	Psychiatric Hospitalizations	☐	☐	Dementia / Alzheimer's Disease
☐	☐	Cardiovascular Disease	☐	☐	Facility Treatment for Addiction	☐	☐	Cognitive Impairment / Disorientation
☐	☐	Hypertension / Hypotension	☐	☐	Hospice Care (at home/in facility)	☐	☐	Alcohol Use Disorder / Dependency
☐	☐	Stroke / TIA	☐	☐	Traumatic Brain or Head Injuries	☐	☐	Any Illegal Substance / Drug Use
☐	☐	Heart Attack / MI	☐	☐	Cirrhosis / Liver Failure	☐	☐	Medication Misuse / Dependency
☐	☐	Hemophilia / Blood Disorders	☐	☐	Sleep Apnea / Sleep Disorders	☐	☐	Self-Harm (plans/attempts)
☐	☐	Congestive Heart Failure	☐	☐	Dialysis / Renal Failure	☐	☐	Threatening or Violent Behavior
☐	☐	Edema / Swelling	☐	☐	Allergies / Anaphylaxis	☐	☐	Bipolar or Mood Disorders
☐	☐	COPD / Asthma / Emphysema	☐	☐	Seizures / Epilepsy	☐	☐	Psychosis: _____
☐	☐	High Cholesterol / Taking Statins	☐	☐	Neurological Disorders	☐	☐	Other mental health issue: _____
☐	☐	Oxygen Therapy	☐	☐	Parkinson's Disease	☐	☐	Anxiety or Panic Disorders — 1=Mild > 4=Severe*
☐	☐	Colostomy / PEG Tube	☐	☐	Immune Disorders	☐	☐	Memory Loss* . . . . . ① ② ③ ④
☐	☐	Diabetes Mellitus	☐	☐	Rheumatoid Arthritis	☐	☐	Chronic Pain* . . . . . ① ② ③ ④
☐	☐	Amputation: _____	☐	☐	Gastrointestinal Disorders	☐	☐	Depression* . . . . . ① ② ③ ④
☐	☐	Cancer: _____	☐	☐	Balance Issues / Falls (2yrs)	☐	☐	PTSD* . . . . . ① ② ③ ④

(Y/N responses are required for **every condition** above – **ANY** unmarked items in the history will result in the exam being sent back **for corrections):**

Describe all **POSITIVE** responses above and include any history of other conditions not listed above:

When was the patient's most recent... (approximate dates/timeframes are acceptable, i.e. Fall 2020)

Flu Vaccine:	Dental Exam:	Vision Exam:

Last Name _____ First Name _____ MI _____ Birthdate _____

Medications and Allergies – Please indicate all allergies and current medications for the patient.

List all allergies, including medications, foods, latex, etc.: ☐ Patient has no known allergies	
1.	4.
2.	5.
3.	6.

List all current medications – attach list as needed	
1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

Physician initial here: x _____ *(I confirm that the medications annotated above are accurate and current)*

Physical Examination: (completed by provider ONLY (MD, DO, NP, or PA)

Current Vital Signs: All vital signs must be recorded on the date of the physical examination
ANY blank areas under the physical examination will delay processing.
***MUST** Include explanation, description, or notes for any indication of abnormalities or health concerns.*

Date Vitals Were Taken

Blood Pressure:		**Temperature:**		**Height:**	
Respiratory Rate:		**Pulse:**		**Weight:**	

ABN	NOR	Indicate whether or not the following systems are normal - If abnormal, explain:	
☐	☐	HEENT: Head, eyes, ears, nose, throat	
☐	☐	Cardiovascular:	
☐	☐	Lungs:	
☐	☐	Thyroid:	
☐	☐	Abdomen:	
☐	☐	Lymphatic:	
☐	☐	Neurological:	
☐	☐	Extremities:	
☐	☐	Skin:	
☐	☐	Neck:	

Last Name _____ First Name _____ MI _____ Birthdate _____

Tuberculosis Screening Test: Applicant is required to take a Tuberculosis Screening Test for admission to AFRH

TST test: ☐ Negative ☐ Positive	X-Ray: ☐ Negative ☐ Positive	IGRA: ☐ Negative ☐ Positive
mm Induration: _____mm	If TST is pos.; Chest X-ray results	If TST is pos.; Interferon Gold Test
Date: _____	Date: _____	Date: _____
If positive, list conversion date:	Findings:	Findings:

Signature/Credentials: _____ Date: _____

Stamps and/or copies of test results are accepted but the provider MUST mark result & have handwritten signature, credentials, & date in this field.

Covid-19 Screening and Vaccination Information

Has the patient been tested for COVID-19, if so indicate the type of test given (Molecular[PCR], Antigen [AG], Antibody [AB]), results, and date. Has the patient received a vaccine for COVID-19? If so; identify the vaccine manufacturer and what date/s the doses were administered? **Submit a copy of the CDC vaccination card.** If patient has a health concern or other reason for deciding not to be inoculated, indicate reason (allergies, EUA Emergency Use Authorization, religious objection, not available yet, etc.).

TEST ☐YES ☐NO		**VACCINE** ☐YES ☐NO		**REFUSAL REASON** ☐N/A
TYPE:	☐PCR ☐AG ☐AB	*MFGR:*	☐PFZ ☐MOD ☐OTH	
RESULTS:	☐NEG ☐POS ☐INC/INV	*1ST Dose Date:*		
DATE:		*2ND Dose Date:*		

Yes	No	Indicate whether or not following have occurred within the past 12 months:
☐	☐	a. Does the patient have any chronic or acute health issues, disease, physical limitations, or other ongoing concerns?
☐	☐	b. Has the patient had any recent hospitalizations, if so why/when? (If available, please attach discharge notes/info)
☐	☐	c. Has the patient recently had a significant change in sleep patterns, appetite, weight, general physical fitness, or falls?
☐	☐	d. Is the patient currently on hospice, if so please describe medical condition, mental/physical limitations, etc.?
☐	☐	e. Ongoing therapy, treatments, or medications for chronic pain management, insomnia, or mental health conditions.
☐	☐	f. Does the patient currently smoke or vape? If so, is the patient currently on a cessation program and progressing towards quitting their habit? Smoking is not permitted indoors at AFRH facilities. *Note: During the COVID-19 pandemic, those required to be in quarantine will NOT have any access to outdoor smoking areas.*

Last Name _____ First Name _____ MI _____ Birthdate _____

INSTRUMENTAL ACTIVITIES OF DAILY LIVING

Is the person able to complete the following tasks **INDEPENDENTLY** without assistance from another person (patient may use a device such as a wheelchair, PMD, grab bars, etc. as long as they are able to do so unassisted)?

Yes	No		Yes	No	
☐	☐	Independent Mobility / Ambulation	☐	☐	Self-Directed Medication Management
☐	☐	Transferring Positions / Fall Prevention	☐	☐	Self-Directed Feeding / Nutrition Management
☐	☐	Self-Managed Bathing / Showering	☐	☐	Independent Emergency Response / Safety Procedures
☐	☐	Self-Managed Toileting / Continence	☐	☐	Appointment Keeping / Time Management Skills
☐	☐	Personal Grooming / Dressing / Undressing	☐	☐	Self-Managed Light Housekeeping and Laundry
☐	☐	Manages Community Navigation / Transportation	☐	☐	Independent Financial Management, Shopping, etc.

Describe any type of assistance/accommodation needed (including devices, aid from staff, etc.):

Does the patient have any of the following limitations or require any of the supportive items listed below?

☑Check all applicable items on the list below. ***If an item on list does not apply, draw a line through the item*** ~~*(completely cross it out).*~~

☐ Lacks clear communication	☐ (Legally) Blind/low vision	☐ Deaf/low hearing	☐ Mobility Devices (walker, PMD)
☐ ESL/limited language skills	☐ Wears corrective lenses	☐ Wears hearing aid	☐ Requires braille/sign language
☐ Non-verbal/mute	☐ Bladder incontinence	☐ Bowel incontinence	☐ Service dog (medical/physical)
☐ Vertigo/seizures/fainting	☐ Urinary catheters	☐ Colostomy	☐ Dentures, partials, or bridge
☐ Oxygen tanks/POC system	☐ PEG tube/CVAD port	☐ Amputation/prosthetic	☐ Oral health/dental problems
☐ CPAP machine/sleep apnea	☐ Full/partial paralysis	☐ Non-ambulatory	☐ Instability, weakness, fall-risk

Describe type of assistance/accommodation needed:

Note: Individuals requiring language/communication accommodations (i.e.: braille, visual alarms, etc.), service dogs, mobility devices, or other medical equipment ***may still be considered*** *for an independent living level of care* ***except*** *when staff members must provide regular support to the individual for use/safety.*

Cognitive and Behavioral Health Status: ANSWER ALL ITEMS – **ANY** blank responses will be returned for corrections

Does the patient exhibit any of the following mental health concerns? ***☑ Check any applicable items & ~~cross out if not applicable~~***

☐ Memory Loss	☐ Mood / Emotional Instability	☐ Post Traumatic Stress	☐ Suicide Ideation / Attempts
☐ Confusion / Disorientation	☐ Dysthymia / Anhedonia	☐ Irrational Thoughts	☐ Addictive Behaviors
☐ Wandering / Gets Lost	☐ Anxiety / Panic Disorders	☐ Threatening Behaviors	☐ Self-Harm / Risky Behaviors

Last Name _____ First Name _____ MI _____ Birthdate _____

COGNITIVE, BEHAVIORAL, MENTAL HEALTH QUESTIONS - *Provide an explanation for any **true** statements and **mark** any specific behaviors/items that apply to the patient.*

True	False	Indicate if any of the following are TRUE (primary care physician may attach letter or comments to clarify responses)
☐	☐	1. Demonstrates signs of cognitive decline such as requiring cues/support to perform daily tasks like basic shopping, managing medications, healthcare decisions, nutrition, or ability to navigate independently – gets lost, wanders…
☐	☐	2. Demonstrates decline in the ability to communicate clearly, remember accurately, or make reasonable decisions; and/or shows poor judgement/risk assessment, poor listening/reading comprehension, or has difficulty in expressing ideas – forgetting terms, losing train of thought, repetition of statements …
☐	☐	3. Demonstrates signs of confusion or lack of orientation (person, place, date/time, or situation); if so, describe…
☐	☐	4. If decline in cognition is noted in #1, #2, or #3 above, have you completed a cognitive assessment *(i.e.: MoCA, MMSE…)?* *Assessment:* *Score:* *Date:* (attach copy if available)

True	False	Indicate whether these statements are true or false for this individual (within the past 12 months) *Any incidents/behaviors taking place over 12 months ago that have not been resolved or **pose any risk** should also be disclosed.*
☐	☐	5. Does the patient drink alcohol? How many **servings** of alcohol does the patient drink on an average week? ☐ #_____ beer (**12**oz/can) ☐ #_____ wine (**5**oz glass) ☐ #_____ cocktails/hard-liquor (**1.5**oz/shot)
☐	☐	6. Drinks 7+ servings of alcohol per week (daily habit) and/or occasionally has 4+ servings at a time (binge)? Describe habits…
		7. **Do any of the following statements apply to the patient's use of drugs, alcohol, substances, or other behaviors? If any are true please indicate the substance/behavior and mark any specific items (underline/circle) that apply to their behavior.**
☐	☐	a. Hazardous use - driving intoxicated, falls/injuries, overdosing/black-outs, reckless/illegal activities, risky/erratic behaviors, violence…
☐	☐	b. Use aggravates or causes physical/mental health problems - cirrhosis, COPD, hypertension, cognitive loss, depression, anxiety…
☐	☐	c. Neglects major social/work roles, has developed cravings, or expends a lot of effort/time planning, obtaining, using, recovering…
☐	☐	d. Has had social/interpersonal conflicts due to their behavior or has been withdrawing from activities which exclude the substance/behaviors
☐	☐	e. Has failed at attempts to control behavior, has been increasing quantity/time spent, has developed tolerance, or experiences withdrawal
		Behaviors/Substances: _____ *Specific issues:* _____
☐	☐	8. Has continued to use **any** alcohol, drugs, tobacco or other substance against medical/professional advice or even when the patient is aware of adverse drug interactions, specific use-related illnesses, medical complications, cognitive issues, falls/injuries, psychological/social problems, or otherwise detrimental, dangerous, or hazardous consequences of such use. Explain…
☐	☐	9. Has the patient **EVER** been counseled, sought help, or been diagnosed with AUD, SUD, or another addiction? If true, has the condition been **active** within the past 12 months? Describe any active use or remissions shorter than 12 months. ☐ YES — active or in early remission ☐ NO — in remission longer than 12 months ☐ N/A — no history of this

True	False	Indicate whether these statements are true or false for this individual (occurring within the past 12-24 months) *Any incidents/behaviors taking place over 2 years ago that have not been resolved or **pose any risk** should be disclosed.*
☐	☐	10. Has decreased participation in usual activities, lost interest/quit caring, is bored/listless, lacks enjoyment/motivation; or has had a significant change in the level of self-isolation, sleep disturbances, personal grooming, or disorganization.

Last Name _____ First Name _____ MI _____ Birthdate _____

☐	☐	11. Reports or exhibits feelings of anxiety, sadness, grief, apathy, depression, moodiness, loneliness, helplessness, hopelessness, or worthlessness; or shows signs of distress -- *crying, irritability, frustration, concentration loss, confusion, anhedonia...*
☐	☐	12. Demonstrates signs of behaviors that are antagonistic, menacing, aggressive, combative, hostile, agitated, angry, dangerous, erratic, volatile, or otherwise intimidating – *fights/yells, makes threats/bullies others, exhibits violent or destructive behaviors...*
☐	☐	13. Reports or shows signs of anxiety or post traumatic stress – persistently nervous, withdrawn, detached; has preoccupied/persistent thoughts or behaviors; avoids certain social interactions/activities; or describes overwhelming feelings of fear, dread, or panic.
☐	☐	14. Exhibits signs of delirium, stupor, idiosyncratic/false perceptions, paranoia, hallucinations, or psychosis. Explain:

True	False	**Indicate whether these statements are true or false for this individual (occurring within the past 5 years)** *Any incidents/behaviors taking place over 5 years ago that present an ongoing issue or may still pose a risk should be disclosed - mark specific issues*
☐	☐	Has been medically advised to seek in-patient or out-patient treatment for a psychiatric condition or addictive behavior.
☐	☐	Has intimidated, threatened, or attempted to harm others and/or may represent a safety risk to the community.
☐	☐	Has expressed a desire, attempted or planned self-harm & may pose a danger to themselves or possible risk of suicide.
☐	☐	Some monitoring, evaluation, or support is necessary for decision making, hazard protection, or psychological health / stability.
☐	☐	Requires intervention from staff members on a regular basis to perform basic activities of daily living.
☐	☐	Requires full-time skilled nursing, rehabilitative, hospice care, or long-term care for current healthcare support.
☐	☐	Patient is mentally and physically capable of **living independently** in a community environment with elderly residents.

Level of Care: Provider select recommended level of care for this individual: write **initials** inside the box:

☐ **Independent Living**	**Individual is physically and mentally self-sufficient, stable, and capable of safely managing activities of daily living without supportive services or aid from others**
☐ **Home Health Care**	**Individual is able to manage daily activities independently; however, may require some support from caregivers, monitoring, supervision, and/or minimal assistance on an intermittent basis**
☐ **Assisted Care**	**Includes some assistance from staff with activities of daily living, diversionary activities, protection from hazards, and/or other supportive services on a regular basis**
☐ **Skilled Care**	**Includes professional nursing care and assessment on a daily basis due to a serious condition, which is unstable, or a rehabilitative, therapeutic regime requiring professional staff**

** Stamps are accepted but the provider MUST sign with handwritten signature, license number, and date or the form will be returned.*

Please Print (Stamp is acceptable)

Physician's Name: _____
Credentials*: _____
Street Address: _____
City, ST Zip _____
Phone Number*: _____
Fax Number*: _____

*Credentials, phone number and fax number are required to confirm

Signature, Date and License Number Required

x

Signature*

Date* License Number*

Take this form to OT / PT Therapist

FA

FUNCTIONAL ASSESSMENT

Dear Applicant:

All prospective residents must be able to live independently upon acceptance into the retirement home. The Functional Assessment evaluates the candidate's Activities of Daily Living (ADL's). The attached assessment must be completed by a LICENSED OCCUPATIONAL THERAPIST (OT) or a PHYSICAL THERAPIST (PT) not a physician, nurse, corpsman or other health care professional. If you have questions regarding this assessment, please contact the Public Affairs Office.

Thank you

AFRH

RETURN ASSESSMENT TO:

ARMED FORCES RETIREMENT HOME
PUBLIC AFFAIRS OFFICE #584
3700 NORTH CAPITOL ST, NW
Washington, DC 20011-8400
Fax Number: (202) 541-7519
Telephone: (800) 422-9988 opt. 1

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ARMED FORCES RETIREMENT HOME

Functional Assessment

Form Completed by a Licensed Occupational or Physical Therapist

FA

Last Name _____ First Name _____ MI _____ Birthdate _____

Street Address _____ City _____ State _____ Zip Code _____

This assessment is required for all applicants seeking admission to the Armed Forces Retirement Home and must be completed and signed **ONLY by a licensed occupational or physical therapist: NOT by a doctor, nurse, or other healthcare practitioner, or the resident candidate**. Please answer the following questions based on your professional judgment, observation and functional tests administered during the applicant's visit and initial each page of the assessment. Answers are subject for verification for accuracy purposes and all "Yes" answers need to be explained. "Yes" answers may or may not affect you application approval.

The following responses are to be completed by a LICENSED PHYSICAL THERAPIST or OCCUPATIONAL THERAPIST only. Provider please give a full explanation of ANY positive response to the following:

1. Requires and/or receives assistance using the telephone? (Such as: dialing, receiving, calling 911)

_____ Y N

2. Requires and/or receives assistance with transportation? (such as: planning, driving, bus, plane, taxi usage)

_____ Y N

3. Requires and/or receives assistance on incline, decline, or curbs?

_____ Y N

4. Requires and/or receives assistance shopping? (Such as: clothes, hygiene, grooming products)

_____ Y N

5. Requires and/or receives assistance to recall current events, locations, dates, or names?

_____ Y N

Last Name _____ First Name _____ MI _____ Birthdate _____

Street Address _____ City _____ State _____ Zip Code _____

6. Requires and/or receives assistance with meals? (i.e. feeding, carrying tray, diet management)

Y N

7. Requires and/or receives assistance with maintaining/cleaning living quarters and personal laundry? (Such as: sweeping/vacuuming, making bed, cleaning bathroom, washing garments)

Y N

8. Requires and/or receives assistance with personal hygiene? (Such as: bathing, grooming, dressing) Please indicate specific needs such as a grab bar, bath stool, supervision, or otherwise.

Y N

9. Requires and/or receives therapy services? (to address weight, pain, cognition, ADL, wound care)

Y N

10. Requires and/or receives assistance of a mobility device? (Such as: wheelchair, person, cane, walker, etc.)

Y N

Last Name _____ First Name _____ MI _____ Birthdate _____

Street Address _____ City _____ State _____ Zip Code _____

11. Requires and/or receives assistance with toileting? (i.e. transfer, removing/reapplying clothes) If so, describe any specific requirements or equipment necessary (colostomy, ileostomy, catheter, raised toilet seat, grab bar, bed pan, incontinent supplies, etc.) Y N

_____

_____

_____

_____

12. Requires and/or receives assistance with **transfers**? (From chair, bed, bath, vehicle, etc.) Y N

_____

_____

_____

_____

13. Requires and/or receives assistance for daily decision making? (Such as: cues, supervision) If so, describe cognitive abilities and limitations. Y N

_____

_____

_____

_____

14. Does the individual have difficulty walking distances over 50 feet (with or without resting periods)? Y N

Please indicated the Furthest Distance walked during this session: (Select One)

☐ Over 150 Feet ☐ 26-50 Feet ☐ Less than 10 Feet

☐ 51-149 Feet ☐ 10-25 Feet ☐ Unable to Walk

15. Was there any walking support used during this demonstration: (If so, select all that apply) Y N

☐ Cane / Walker / Crutches ☐ Parallel Bars ☐ Oxygen / Breathing Equipment

☐ Prosthesis ☐ Service Dog (physical/medical) ☐ 1-2 persons assisting

☐ Leaning on something in area ☐ Other: _____

16. Requires and/or uses mobility devices on a regular basis: (select all that apply) Y N

☐ Wheelchair (manual) ☐ Raised Toilet Seat ☐ Escort

☐ Powered Wheelchair / Scooter ☐ Shower chair / Bathing Stool ☐ Grab Bars

☐ Cane / Walker / Crutches ☐ Powered Recliner / Lifting Chair ☐ Other: _____

Functional Assessment

Form Completed by a Licensed Occupational or Physical Therapist

FA

Last Name _____ First Name _____ MI _____ Birthdate _____

Street Address _____ City _____ State _____ Zip Code _____

Y N 17. Requires assistance and/or experiences falls when transferring from mobility device to toilet, bed, bath, etc.?

_____

_____

_____

Y N 18. Requires and/or currently lives in a situation where some assistance is provided (within past 6 months)? Select the living situation/s which best describes the individual's recent accommodations:

Independent Living Situations:

- ☐ Homeowner (House, Condo, etc.)
- ☐ Renting or Leasing (Apartment, etc.)
- ☐ Independent Senior (over 50) Living Community
- ☐ Independent – Traveling, RV, or Nomadic Lifestyle
- ☐ Other: _____

Living Situations with some assistance given:

- ☐ At Home, with some aid from Family or Caretaker
- ☐ Receiving Home Health Care in Home/Apartment
- ☐ Assisted Living Facility
- ☐ Nursing Home
- ☐ Other: _____

Y N 19. Does this person currently with a family member or somebody else? If so, with whom (response is optional)?

☐ Lives Alone ☐ Lives with Family or Spouse ☐ Lives with a roommate or friend

Name: _____

Relationship: _____

Y N 20. Who participated in this assessment?

☐ Applicant ☐ Family Member ☐ Significant Other / Spouse

☐ Caretaker ☐ Friend ☐ Other: _____

Your signature below indicates that you have assessed this individual and the answers to the questions are accurate based on your professional judgement as a LICENSED OCCUPATIONAL OR PHYSICAL THERAPIST

Printed Contact information* (Stamp is acceptable)	
Therapist Name:	
Title:	
Street Address	
City, ST ZIP	
Phone Number	
Fax Number*	
*REQUIRED INFORMATION	

Signature and License Number Required

Signature _____ Date _____

☐ Occupational Therapist ☐ Physical Therapist

License Number _____ State _____

END

OT/PT please initial EACH page: _____

The attached Mental Health Evaluation is ONLY required for candidates identified as having a history of certain conditions:

If any of the following apply to you, then you may be contacted by AFRH to complete the attached mental health evaluation:

- Did you receive a **NOTIFICATION** from AFRH to submit a Mental Health Evaluation?
- Did your physician or occupational/physical therapist indicate a history of any mental health conditions, substance use/dependency, or cognitive impairment on the medical exam or functional assessment?
- Do you have PTSD?
- Have you ever been dependent on Alcohol?
- Have you ever been dependent on any substance (medication, drug, chemical or other substance)?
- Have you ever been treated by a health care provider or counselor for ANY psychiatric condition?
- Have you recently experienced a loss or other event that has impacted your usual mood or ability to cope with stress?
- Have you ever had any issues with memory loss, confusion, or disorientation?
- Are you taking any medications for:
    a. psychiatric conditions
    b. depression
    c. anxiety
    d. dementia
    e. sleep disorders
    f. fibro myalgia
    g. mood stabilizers
    h. chronic pain medications

If any of the above questions apply to you or if AFRH has **NOTIFIED** you that the medical review board requires a Mental Health Evaluation to make a determination, please have the attached form completed by **PSYCHIATRIST** or **PSYCHIATRIC NURSE PRACTITIONER.**

The form may be submitted with your application package or if you have already sent in the application package, form may be submitted by FAX at (202) 541-7519

For your protection, please call (800) 422-9988 option 1 and speak with the public affairs office prior to FAXING the form so that we know it will be arriving.
–Thank you!

Please note that the request to submit this information does not imply that any candidate will be denied or granted admittance to AFRH. Persons with a history of mental health conditions may be eligible upon a judgement and satisfactory determination by AFRH that the Home is able to care for the individual with the existing facilities and services of the Home. ***Individuals applying to the home must be physically and mentally able to live independently.*** *AFRH is not equipped to provide continual observation, assessment and treatment of individuals with active psychiatric problems, substance abuse, or cognitive impairment.*

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Take this form to
Psychiatrist/Psych NP

MHE

MENTAL HEALTH EVALUATION

The AFRH Chief Operating Officer requires a full psychiatric evaluation be completed by a **LICENSED PSYCHIATRIST OR PSYCHIATRIC NURSE PRACTTITONER** for all applicants who have been identified as having any possible psychiatric, cognitive, or other mental health conditions.

AFRH will notify all applicants who are required to submit the Mental Health Evaluation

NOT ALL APPLICANTS WILL BE REQUIRED TO HAVE THIS FORM COMPLETED – PLEASE CONTACT AFRH IF YOU HAVE QUESTIONS REGARDING THIS FORM
AT (800) 422-9988 Option 1 FOR GUIDANCE

Dear Applicant:

AFRH requires the completion of a comprehensive mental health evaluation for any applicant *identified as having a history of psychiatric conditions, substance use disorders, and/or cognitive impairment*. Not every applicant will be required to have this evaluation completed, ONLY individuals with any indication or history of mental health conditions are required to have a LICENSED PSYCHIATRIST OR PSYCHIATRIC NURSE PRACTITIONER (not a family physician, psychologist, counselor, nurse, social worker, or other mental health professional who does not have a prescribing license) complete this evaluation.

Should you have a known history of ANY of the above conditions or *if you receive notification from AFRH requesting an evaluation*, please have a LICENSED PSYCHIATRIST OR PSYCHIATRIC NURSE PRACTITIONER provide detailed responses to the attached Mental Health Evaluation. Telehealth appointments are acceptable. Please request an electronic/fax copy of the form be sent to their office for the psychiactric provider to complete.

The request for this information, does not imply that the applicant will be granted nor denied admission to AFRH; however, if the applicant does not submit the information as requested, the application will remain pending until received.

Please have your psychiatric provider submit the completed form directly from their office.

RETURN EVALUATION TO:

ARMED FORCES RETIREMENT HOME
PUBLIC AFFAIRS OFFICE #584
3700 NORTH CAPITOL ST, NW
Washington, DC 20011-8400
Fax Number: (202) 541-7519
Phone: (800) 422-9988 Option 1
(please call prior to faxing any documents)

Any additional information that the examiner would like to include with this evaluation may be written here if extra space is needed.

Patient's name: _____ DOB: _____

Comments:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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_____

_____

_____

_____

_____

_____

Signature & Date

Clear Data

ARMED FORCES RETIREMENT HOME

Mental Health Evaluation

Form Completed by a Licensed Psychiatrist Only

MHE

Patient Last Name | First Name | MI | Birthdate

Street Address | City | State | Zip Code

The following responses are to be completed by a LICENSED PSYCHIATRIST/PSYCHIATRIC NP only – Please attach any relevant explanations, records, and test results as needed to provide a full professional description of the individual's mental health status.

A. Please indicate whether the applicant has ever had any history of the following:

☐ Yes ☐ No	Any Psychiatric Hospitalizations or Admissions to Addiction Treatment Facilities	☐ Yes ☐ No	Self-Harm or Suicide attempts or planning, or Suicidal Ideation
☐ Yes ☐ No	Any Psychiatric Diagnosis or Treatment for Psychiatric Conditions or Symptoms	☐ Yes ☐ No	Major Depressive Syndrome, Bipolar Disorder, or other Mood Disorder
☐ Yes ☐ No	Any Substance Use Disorders including Alcohol, Illicit Drugs, or Prescription Medications	☐ Yes ☐ No	Mild/Moderate Depression, Anhedonia, Dysthymia, or Grief Reaction
☐ Yes ☐ No	Any History of Aggression, Violence, and/or Erratic or Threatening Behaviors	☐ Yes ☐ No	Alzheimer's Disease, Dementia, or other Cognitive Impairment
☐ Yes ☐ No	Post-Traumatic Stress Disorder (PTSD) and/or other Anxiety Disorders	☐ Yes ☐ No	Mild/Moderate Memory Loss, Disorientation, or Cognitive Decline
☐ Yes ☐ No	Psychotic Disorders:	☐ Yes ☐ No	Neurological Disorders:

B. Psychiatric Medications:

Treatment Ongoing		List any psychiatric medications prescribed within the past 5 years *Please indicate medication, indications, and whether the treatment is ongoing or has been discontinued*	
True	**False**	**Medication**	**Indications**
☐	☐		
☐	☐		
☐	☐		
☐	☐		

C. Describe any ongoing psychiatric conditions or issues:

True	False	Indicate whether these statements are true or false for this individual (occuring within the past 12-24 months) *Any incidents/behaviors taking place over 2 years ago that have not been resolved or **pose any risk** should be disclosed. If any of these statements are **true, provide an explanation**. Indicate whether any conditions are currently controlled or unstable.*
☐	☐	1. Reports or exhibits feelings of anxiety, sadness, depression, loneliness, apathy, helplessness, hopelessness, or worthlessness; or shows signs of emotional distress such as increased or uncontrolled crying, mood swings, listlessness, or otherwise. Please observe emotional status during the exam as well as what the patient reports.
☐	☐	2. Reports discontinuing their usual activities or interests, feeling bored/apathetic, or lacking motivation; or has had a significant change in level of self-isolation, sleep disturbances, personal grooming, or disorganization.
☐	☐	3. Reports or exhibits signs of antagonistic, aggressive, combative, threatening, or hostile behaviors. Shows signs of erratic behavior, sympathetic hyperactivity, irritability, poor anger management, or other volatile emotional states. Please note any observations made during examination as well as what the patient reports.

Patient Last Name | First Name | MI | Birthdate

Street Address | City | State | Zip Code

☐	☐	4. Reports or exhibits signs of anxiety or post traumatic stress such as preoccupied or persistent thoughts and behaviors, detachment, use of avoidance tactics, or experience of emotional affects such as fear, dread, or panic.
☐	☐	5. Exhibits signs of delirium, stupor, idiosyncratic/false perceptions, paranoia, hallucinations, or psychosis. Provide an explanation:
☐	☐	6. Has the individual had any history of psychiatric admissions to a hospital or treatment facility? If so, describe:
☐	☐	7. Has the patient ever attempted or threatened to harm themselves or others? Explain any risky behaviors; self-harm or suicidal ideation, planning, or attempts; and/or threatening, aggressive, hostile, or violent behaviors.

D. Describe any ongoing alcohol/substance use conditions or other addictions:

True	False	**Indicate whether these statements are true or false for this individual (within the past 12 months)** *Any incidents/behaviors taking place over 12 months ago which are unresolved or **pose any risk** should also be disclosed.*
☐	☐	8. Does the individual drink alcohol? If true, how many servings of alcohol does the patient usually drink on a weekly basis? *(fill in the number of servings)* ☐ #_____ beer (12oz/can) ☐ #_____ wine (5oz/glass) ☐ #_____ cocktails/hard-liquor (1.5oz/shot)
☐	☐	9. Does the patient normally have 7+ servings of alcohol per week (daily basis), or have any occasions where they drink 4+ servings in a single day (binge drinking). If so, describe…
☐	☐	10. Uses ANY medications, drugs, or other substances for recreational purposes, intoxication/stimulation, in excess of dosage or longer than prescribed, or for reasons other than medically indicated. Describe…
☐	☐	11. Signs or reports of cravings/urges to use; has increased use (quantity/time spent/frequency) over time; or has desire to control or reduce the behavior/substance use but has been unsuccessful in achieving this goal.
☐	☐	12. Has developed tolerance *(needing more to achieve intoxication/effects)* or experiences withdrawal symptoms if abstaining which are relieved by using again. *(headaches, nausea, blackouts, hang-overs, tremors, DT's, etc.)*

Patient Last Name | First Name | MI | Birthdate

Street Address | City | State | Zip Code

☐	☐	13. Continues to use **ANY** alcohol/drugs even when the person is aware of their own specific use-related illnesses, medical complications, adverse drug interactions, psychological disorders, cognitive problems, or hazardous behaviors *(driving intoxicated, falling/injuries, fighting, illegal activities, etc.)* which are either caused or aggravated by use of the substance. Describe…
☐	☐	14. Reports experiencing negative social, occupational, economic, or legal consequences resulting from or indirectly related to their alcohol/drug use. *(i.e. inability to fulfill family/work roles, tardiness/absences, job reprimands/loss, interpersonal conflicts, divorce, cognitive/memory problems, arrests/DUI, homelessness, etc.)*
☐	☐	15. Does the patient meet criteria for diagnosis (or ever been diagnosed) with alcohol use disorder (AUD), substance use disorder (SUD), or another addictive behavior? If they have been given a screening test *(i.e.: AUDIT, MAST, SSI-AOD, etc.)*, which assessment was used and what were the results? *Assessment:* *Score:* *(Please attach a copy)*
☐	☐	16. If individual meets criteria for AUD/SUD, has the patient been sober or in remission from their addiction for a minimum of 12 months? If they are still actively using alcohol/drugs or only recently stopped, please explain. *(write n/a if this question does not apply to the patient)*
☐	☐	17. Has the patient sought or been advised at any point to seek counseling, treatment, professional help, or otherwise for maladaptive substance use, behaviors, or addictions? Based on your professional assessment, would you recommend counseling or treatment for this patient. If so, describe…

E. Describe any ongoing cognitive issues:

True	False	Indicate if any of the following are TRUE
☐	☐	18. Demonstrates signs of cognitive decline such as requiring cues/support to perform daily tasks such as healthcare management, decision making, safety, or ability to navigate independently *(i.e. gets lost/wanders).*
☐	☐	19. Demonstrates decline in the ability to communicate clearly, remember accurately, or make reasonable decisions; and/or shows poor judgement/risk assessment, poor listening/reading comprehension, or has difficulty in expressing ideas (forgetting terms, losing train of thought, repetition of statements, etc.).
☐	☐	20. Demonstrates signs of confusion or lack of orientation (person, place, date/time, or situation); if so, describe…

Patient Last Name | First Name | MI | Birthdate

Street Address | City | State | Zip Code

☐	☐	21. Receiving treatment for or diagnosed with dementia, cognitive impairment, or Alzheimer's disease. Describe condition, medications, support needs, etc.:
☐	☐	22. If any of the questions in this section (#18-21) are true, complete an evaluation for decline in cognitive abilities. Indicate assessment administered such as MoCA, MMSE, etc. and give results: (attach copy if available) *Assessment:* *Score:*

F. Suitability for independent living in a senior living community

True	False	Indicate if any of the following are TRUE
☐	☐	23. Are there any limitations in the individual's Instrumental Activities of Daily Living (IADL's) due to cognitive decline, addictive behaviors, or other mental health conditions? ☐ Ability to communicate clearly ☐ Personal financial management, banking, etc. ☐ Personal hygiene, housekeeping, laundry, etc. ☐ Safety procedures and emergency responses ☐ Transferring, fall prevention, independent mobility ☐ Toileting and continence (bowel and bladder) ☐ Navigation, transportation, community mobility ☐ Self-directed medication management ☐ Nutrition management, feeding and maintenance ☐ Time management, arranging appointments, etc. ☐ Basic shopping for necessities and grocery Items ☐ Interpersonal relationship skills, communications
☐	☐	24. Does the individual require **any support** from staff or other mental health professionals in order to remain stable and fully independent? *(Such as supervision, monitoring, evaluations, counseling, prescriptions, etc.)*
☐	☐	25. Is the individual able to **live independently in a community environment with elderly residents**?
☐	☐	26. Does the individual pose **any risk** to themselves or other people?

Should you have any additional questions, please contact AFRH Public Affairs Office at (800) 422-9988 (prompt 1) or directly at (202) 541-7550

Print Contact Information (Stamp is acceptable) REQUIRED	
Examiner's Name:	
Credentials:	
Street Address	
City, ST ZIP	
Phone Number*	
Fax Number*	

Signature and License Number Required	
Signature	Date
License Number	State

Must supply phone# and fax# for verification of information provided.

Please have the psychiatric provider submit the completed form directly from their office to AFRH: FAX 202-541-7519.

Patient Last Name _____ First Name _____ MI _____ Birthdate _____

MEDICAL RECORD RELEASE FORM

PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C 136, Under Secretary of Personnel and Readiness; 24 U.S.C. 401, Armed Forces Retirement Home; DoD Directive 5124.09 Assistant Secretary of Defense for Personnel and Readiness Force Management; DoD Instruction 1000.28, Armed Forces Retirement Home (AFRH); and E.O. 9397 (SSN), as amended.

PURPOSE: To determine and verify eligibility for admission to the AFRH.

ROUTINE USE(S): In addition to those disclosures generally permitted under 5 U.S.C. 552a(b) of the Privacy Act of 1974, as amended, the records contained herein may specifically be disclosed outside the DoD as a routine use pursuant to 5 U.S.C. 552a(b)(3) as follows: To the Federal Reserve for processing the debt on the resident account; To authorized contractors or vendors for the purpose of providing medical services to the residents of the Armed Forces Retirement Home; To any Federal agency which provides medical services to residents of the Armed Forces Retirement home; To the Inspector General of the Department of Defense or his/her designee, for conducting inspections of AFRH records; To a Federal agency, or an organization or person contracting with the AFRH for information needed in the performance of official duties related to reconciling or reconstructing data files, compiling descriptive statistics, and/or making analytical or financial studies to support the function for which the records were collected and maintained; Law Enforcement Routine Use; Congressional Inquiries Disclosure Routine Use; Disclosure of Information to the National Archives and Records Administration Routine Use; Disclosure to the Merit Systems Protection Board Routine Use; and Data Breach Remediation Purposes Routine Use.

The applicable system of records notice is DPR 38 DoD, Armed Forces Retirement Home electronic Resident Information System (eRIS) and is available at: (ADD LINK WHEN PUBLISHED).

DISCLOSURE: Voluntary; however, failure to provide the required information may result in the delay or denial of admission.

Medical Record Release Form

PMRF

Patient Last Name _____ First Name _____ MI _____ Birthdate _____

MEDICAL INFORMATION DISCLOSURE FORM:

*SIGNATURE OF RELEASE IS **REQUIRED** FOR PROCESSING OF ANY MEDICAL FORMS*

Patient's Name:				Birthdate:	
Street:		Apt.:			
City:		State:		Zip:	
Phone:		Cell:			
Email:					(if available)

Healthcare providers: Applicants must include the examiner's Name, Phone, and FAX numbers for the psychiatric professionals who completed the mental health evaluation form.

Psychiatric Care Provider* – Completed the Mental Health Evaluation Form
(must be a licensed Psychiatrist or Psychiatric Nurse Practitioner)

Examiner's Name :				Credentials*	
Street:		Clinic:			
City:		State:		Zip:	
Phone*:		Fax*:			
Email:					(If provided, email is only to be used for contact not submission of patient information)

I grant my permission to disclose information to:

☐ Armed Forces Retirement Home
3700 North Capitol Street, NW
Washington, DC 20011

Attn: Admissions Board
Public Affairs Office #584
Tel: 202-541-7922 Fax: 202-541-7519

Specific information to be disclosed:

- ☐ Medical Records covering the last 12 months
- ☐ Insurance records
- ☐ Records of drug, alcohol, & substance use disorders
- ☐ HIV/AIDS-Related Information and test results
- ☐ Patient history and office notes
- ☐ Billing records
- ☐ Mental Health records
- ☐ COVID-19 Related Information and test results

I understand that release of this information is provided on a voluntary basis in accordance with the Privacy Act Statement Authority: 10 U.S.C 136; 24 U.S.C. 401 (full version is provided on the cover page of the application) to determine and verify eligibility for admission to the Armed Forces Retirement Home. I understand that I may revoke this authorization at any time by giving written notice to AFRH at the aforementioned address. I also understand the revocation of this authorization will not affect any action taken by AFRH in reliance on this authorization prior to receipt of a written revocation.
I fully acknowledge that failure to provide any required information may result in the delay or denial of admission to the Armed Forces Retirement Home.

Patient's Signature*	***Date****

* Signature of this release is REQUIRED for processing of any medical forms submitted with the application for residency.