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 psychiatric 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.