



## Telephone Numbers and Websites

**Veterans Affairs Health Care**

877.222.8387

**Veterans Affairs Benefits**

800.827.1000

**Veterans Crisis Line**

800.273.8255 (press 1)

**National Caregiver Support Line**

855.260.3274

**Veterans Affairs Website**

<http://www.va.gov>

**Returning Servicemembers Website**

<http://www.oefoif.va.gov>

**VA Caregiver Support:**

**Caring For Those Who Care**

<http://www.caregiver.va.gov>

**eBenefits**

<http://www.ebenefits.va.gov>

**MyHealthVet**

<http://www.myhealth.va.gov>

**National Center for PTSD**

<http://www.ptsd.va.gov>

**Make The Connection**

<http://makehconnection.net>

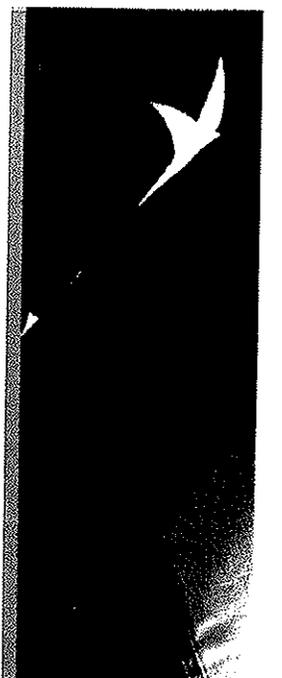
*Geeta Isardas, LCSW, USA  
VA Liaison for Healthcare  
808-348-5657*

**VA Liaison Program**  
VA Liaisons for Healthcare assist Servicemembers preparing to separate from the military and new Veterans with the transition of their healthcare from DoD to VA. Collaboration between the referring Military Treatment Facility and the receiving VA Healthcare Facility ensures that care needs, including specialized services, are identified and arranged at the VA location that will best meet the Servicemember's or Veteran's current healthcare needs.



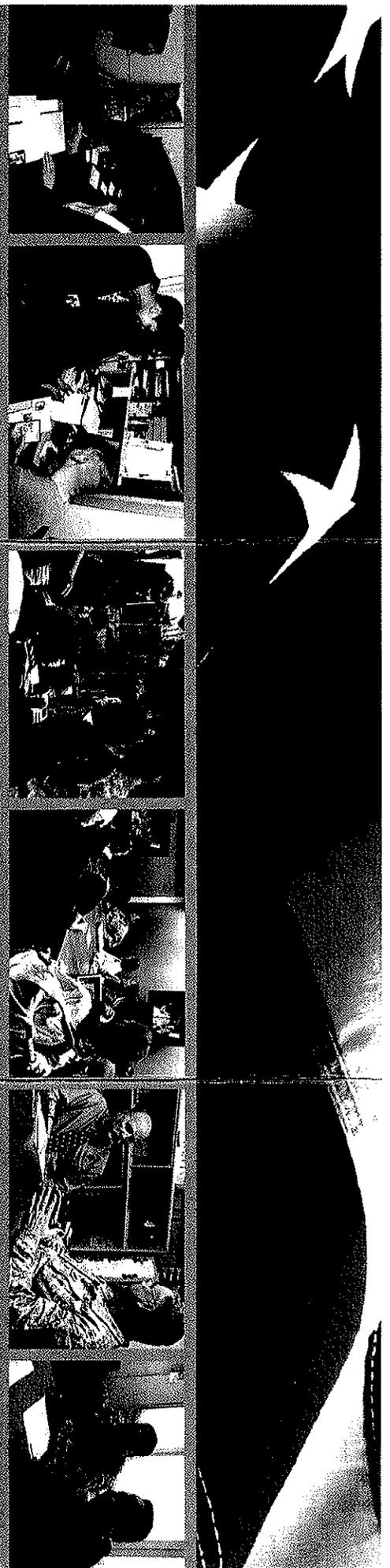
 VA Care Management and Social Work Service  
Care and Compassion Across the Continuum

 Veterans Health Administration  
Employee Education System



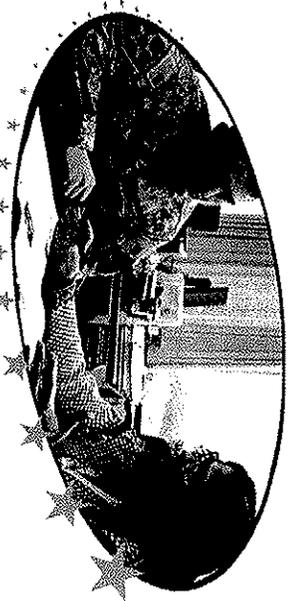
**VA HEALTH CARE**

Defining  
**EXCELLENCE**  
in the 21st Century



## VA Liaison Program

Since 2003, VA Liaisons for Healthcare have been assisting ill and injured Servicemembers by facilitating their transition from the Department of Defense to VA Healthcare Facilities. VA Liaisons are located at Military Treatment Facilities with high concentrations of ill and injured Servicemembers. VA Liaisons for Healthcare meet with Servicemembers early in their transition to ensure access to VA healthcare programs at the appropriate time in the recovery and rehabilitation process of the Servicemember. VA Liaisons coordinate the transition of healthcare to both inpatient and outpatient programs at VA facilities nationwide.



## VA Liaisons for Healthcare:

- ★ Are Licensed Clinical Social Workers or Registered Nurses
- ★ Work with clinical staff at both Department of Defense (DoD) Military Treatment Facilities (MTFs) and Department of Veterans Affairs (VA) Healthcare Facilities
- ★ Coordinate with clinical staff and case managers to review ongoing treatment plans and expedite the transition process
- ★ Collaborate with the MTF healthcare team to identify ongoing healthcare needs for ill and injured Servicemembers
- ★ Arrange care at the VA Healthcare Facility that can best meet Servicemembers' needs, closest to their home
- ★ Facilitate inpatient transfers from DoD to VA Healthcare Facilities
- ★ Educate Servicemembers, Veterans, their families and Caregivers about VA healthcare benefits and services
- ★ Meet with Servicemembers, Veterans, their families and Caregivers to discuss the VA system of care and the Servicemember's individual healthcare needs
- ★ Explain initial eligibility processes to Servicemembers, Veterans, their families and Caregivers
- ★ Register the Servicemember at the identified VA Healthcare Facility before leaving the MTF
- ★ Obtain scheduled outpatient appointments ahead of departure from MTFs
- ★ Connect the Servicemember with the Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn (OEF/OIF/OND) Program Manager who will coordinate ongoing care at the nearest VA Medical Center
- ★ Collaborate with federal, state and community agencies and programs that assist Servicemembers, Veterans, their families and Caregivers during the transition process

## CHECKLIST FOR REFERRAL TO VA LIAISON

- MTF referral form
- Narrative summary
- MEB results
- Most recent medication list
- Most recent behavioral health note
- Most recent note from each clinic (last 30 days or if medically significant)
- VA OIF/OEF/OND Post-Deployment Screening forms
- If the SM is going to be on transition leave for 30 days or more, a TRICARE authorization for supplemental care is needed (unless staying near an MTF)

Notes: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Mahalo!

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 Health Care at your MTF. If there is not a VA Liaison assigned to your facility, please forward this form directly to the OEF/OIF Program Manager at the requested VA Health Care Facility.

Military Treatment Facility		Date of Referral
MTF Referral Source	Phone Number	Cell/Pager Number
Military Social Worker/Case Manager (If different than referral source)	Phone Number	Cell/Pager Number
VA Liaison for Health Care	Phone Number	Cell/Pager Number

**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	DOB	Mother's Maiden Name
Age	Religion	Marital Status	Place of Birth (City&State&Zip)
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Is the patient Spanish, Hispanic, or Latino? <input type="checkbox"/> Yes <input type="checkbox"/> No		
What is Patient's Race? (You may check more than one.) (Information is required for statistical purposes only.)		<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Native Hawaiian or Other Pacific Islander
		<input type="checkbox"/> Asian	<input type="checkbox"/> White <input type="checkbox"/> Black or African American
Father's Name		Mother's Name	

**EMERGENCY CONTACT**

<input type="checkbox"/> Next-of-Kin	<input type="checkbox"/> Family	<input type="checkbox"/> Durable Power of Attorney for Health Care
Name	Relationship	
Complete Address & City & State & Zip		
Home Phone Number	Cell Phone Number	Does the Patient have an Advance Directive? <input type="checkbox"/> Yes <input type="checkbox"/> No

**PATIENT MILITARY INFORMATION: (complete details in these responses aid in the planning of long term veterans benefits)**

Branch of Military	<input type="checkbox"/> Army	<input type="checkbox"/> Air Force	<input type="checkbox"/> Navy	<input type="checkbox"/> Marine Corps	<input type="checkbox"/> Coast Guard	Rank
Component	<input type="checkbox"/> National Guard	<input type="checkbox"/> Reserve	<input type="checkbox"/> Active	<input type="checkbox"/> OIF	<input type="checkbox"/> OEF	<input type="checkbox"/> N/A (non-OIF/OEF)
Service Status:	<input type="checkbox"/> Active Duty (currently)	<input type="checkbox"/> Retired - Date of retirement	<input type="checkbox"/> TDRL	<input type="checkbox"/> PDRL		
Service Entry Date	ETS	Release from Active Duty				
Combat Dates & Theater (locations)						
Parent Command & POC & Phone Number						
<input type="checkbox"/> In process of discharge:	<input type="checkbox"/> ETS	<input type="checkbox"/> MEB	<input type="checkbox"/> Limited Duty	<input type="checkbox"/> Admin Sep	<input type="checkbox"/> Other:	
Anticipated date of separation (if known):				Status of MEB/PEB:		

Patient's Last Name:	Patient's SSN:
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**MTF HEALTH CARE TREATMENT AND PLAN**

Date of injury: \_\_\_\_\_  BI  NBI  Disease/ Disorder

INJURY/COMBAT RELATED INJURY/DIAGNOSIS DETAILS:

DISCHARGE PLAN from Military Treatment Facility [to include WHEN and WHERE patient will be d/c & discharge status, i.e. TDRL, convalescent leave pending medical d/c, convalescent leave pending return to duty, Con Lv pending return to MTF, etc]:

1) What is the estimated departure date from MTF or arrival date home? (so VHA can arrange follow-up care):

2) Has MTF Case Manager requested a TriCare /MMSO authorization?  YES  NO If so when was clinical order entered?

3) Name of Attending Physician and Contact Number(s):

4) Name of Nurse/Nurses' Station Ward and Contact Number(s):

**REQUEST FOR VA HEALTH CARE. Must be Completed by a MTF Health Care Clinician (i.e. Case Manager/SW/MD)**

Requested VA Health Care Facility:

Is patient a VA Employee  YES  NO

REQUESTED HEALTH CARE: *please check all that apply, and provide corresponding medical records.*

**INPATIENT CARE**

- Traumatic Brain Injury
- Spinal Cord Injury
- Mental Health (Psychiatry, PTSD, Substance Abuse)
- Blind Rehabilitation
- Long-term care/Nursing Home
- Other:

**OUTPATIENT CARE**

- Primary Care:
- Mental Health (Psychiatry, Psychology, PTSD, Substance Abuse):
- Therapy (PT, OT, Speech):
- Pain Management:
- Visually Impaired Services:
- Durable Medical Equipment/Prosthetics:
- Specialty Clinics (Neuro, Ortho, Cardiology, ENT, wound care, suture removal, Audiology):
- TBI/Polytrauma:
- Other:

Please indicate the plan for the transfer of Medical Records:

**NOTE: At the time of the patient transfer the discharge summary and current discharge medication list will need to be included.**  
*(if referring to an inpatient setting (i.e. Polytrauma Center, TBI, SCI), or if clinically indicated (i.e. ortho, surgery) please request a CD of patient's films)*

Patient's Last Name:

Patient's SSN:

<b>[As appropriate:] REFERRALS TO POLYTRAUMA WILL NEED TO INCLUDE THE FOLLOWING:</b>	
<input type="checkbox"/>	History & Physical
<input type="checkbox"/>	Notes from theater, Germany, Medivac flight note, etc.
<input type="checkbox"/>	MD progress notes. If pt has fractures include ortho note w/ weight bearing status & any other restrictions.
<input type="checkbox"/>	Include notes from Specialty Services i.e. neurosurgery, neurology, ID, plastics, ophthalmology
<input type="checkbox"/>	Current lab work: CBC, comprehensive metabolic panel, urinalysis, and others as appropriate (i.e. INR, arterial blood gases, etc)
<input type="checkbox"/>	Cumulative microbiology results
<input type="checkbox"/>	Cumulative results of cerebrospinal and any other fluid analysis (i.e. pleural, ascitic, synovial, etc.)
<input type="checkbox"/>	Current medications
<input type="checkbox"/>	Radiology reports for CT scans, MRI's, ultrasounds, vascular studies, special procedures, angiograms & list of radiology studies performed
<input type="checkbox"/>	OR notes (especially regarding all implanted devices such as pegs, trachs, stents, filters, etc.)
<input type="checkbox"/>	Recent therapy notes from OT, PT, & SLP
<input type="checkbox"/>	Neuropsychology testing performed
<input type="checkbox"/>	Social Work psychosocial assessment
<input type="checkbox"/>	Interim summary describing the hospital course and complications to date

Patient's Last Name:	Patient's SSN:
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