

JAMES A. HALEY VETERAN'S HOSPITAL AND CLINICS

POST-DEPLOYMENT REHABILITATION AND EVALUATION PROGRAM



James A. Haley Veterans' Hospital & Clinics

13000 Bruce B. Downs Blvd.

Tampa, FL 33612

Approved by Hospital Veteran/Family Health Education Committee 2020 #x

JAMES A. HALEY VETERAN'S HOSPITAL AND CLINICS
POST-DEPLOYMENT REHABILITATION AND EVALUATION PROGRAM

PREP

REFERRAL PACKET

Mission Statement

Our mission is to provide each Active Duty Service Member with compassionate, state-of-the-art individualized treatment services focusing on rehabilitation and mental health needs. Community reintegration and a comprehensive plan for restoration of function are paramount. Our ultimate aims are to assist in improving functional abilities, reducing symptom complaints, stabilizing psychological distress while restoring confidence and a sense of mastery, enhancing family relationships, and assisting Service Members with ongoing recovery.

Program Overview

PREP is a mild Traumatic Brain Injury (mTBI) inpatient rehabilitation program based on individualized evaluation and treatment needs. PREP includes comprehensive individualized evaluations and initiation of treatments for combat-related physical, cognitive, and mental health symptoms.

Emphasis is placed on persistent post-concussive symptoms, post-deployment readjustment issues and emotional functioning. Our treatment is collaborative and facilitated by an interdisciplinary team that can address both rehabilitation and mental health needs simultaneously.

Individualized treatment plans commonly include:

Audiology	Occupational Therapy
Cognitive Rehabilitation	Pain Focused Psychotherapy
Community Reintegration	Physical Therapy
Creative Arts	Social Work Case Management
Dual Task	Speech
Evidence-Based Trauma Therapy	Vestibular Therapy
Headache Therapy	Vision therapy
Insomnia and Apnea Treatment	Vocational Rehabilitation
Neuropsychological Assessment	

For questions about the Referral process and Admissions, please contact the Admissions Coordinator
at

Patient For additional questions about the program please contact:

Telephone: (813) 972-2000 or Toll Free: (888) 716-7787

PREP Point of Contact at Ext. 3415

Email: Jessica.Wentworth@va.gov

Admission Coordinator at ext. 6149

Email: Debbie.Shepherd@va.gov

REFERRAL INFORMATION

Please note that items marked with an asterisk (*) are required in order to process the referral.

Date of Referral: _____

*Referring Clinician: _____

*Phone Number/email: _____

*Referring Case Manager/Social Worker: _____

*Phone Number/email: _____

*Referring Organization: _____

***Available dates: Option:**

1. _____

2. _____

3. _____

*Last Rank MOS: _____

*Veteran's Last Name: _____

*Veteran's First Name: _____

*Veteran's MI _____

*Veteran's SSN _____

*Veteran's DOB: _____

*Veteran's address: _____

*Veteran's Phone Number: _____

*Veteran's Email: _____

Travel Clearance: Veteran is *medically* cleared for individual travel by the one of the following modes of transportation:

☐ - Privately Owned Vehicle, Train, or Bus

☐ - Commercial Air

*Signature of Medical Provider

* Print Name

*Date

*Signature, Print Name and Date above can **ONLY** be completed by a **Medical Provider** who can clear the patient for travel.

VETERAN'S DEMOGRAPHICS (please circle one/fill in the blanks)

Status: ☐ Veteran ☐ Reservist ☐ National Guard ☐ Military Retired

Branch of Service: ☐ Army ☐ Navy ☐ Marines ☐ Air Force ☐ Coast Guard

MARITAL STATUS:

☐ Never ☐ Married ☐ Domestic Partner ☐ Separated

☐ Divorced ☐ Widowed

Gender: ☐ Female ☐ Male ☐ Other

What is the patient's preferred language for discussing healthcare?

Does the patient currently utilize a Personal Health Information (PHI) system? Yes No

MEB/IDES process initiated? Yes No N/A If Yes, what is the current status?

Are there pending or history of military/civilian legal issues, including arrests, LOD investigations?

Yes No

If Yes, please
elaborate:_____

MEDICAL INFORMATION

Purpose of the Referral:

Is the Patient willing and able to fully participate in the Program? Yes No

Date(s) and Mechanism of Injury:

Any admissions/hospital stays within the past 60 days (Psychiatric/Medical): Yes No

If Yes, please
elaborate:_____

Please answer the following:

1. How often do you have a drink containing alcohol?

Never Monthly or less 2-4 times a month 2-3 times a week 4 or more times a week

2. How many standard drinks containing alcohol do you have on a typical day?

1 or 2 3 to 4 5 to 6 7 to 9 10 or more

3. How often do you have six or more drinks on one occasion?

Daily or almost daily Weekly Monthly Less than monthly Never

Have you used illicit substances in the past year? YES NO

If yes, which ones?

What is the Patient's current medication list? (if more than four, please provide current medication printout). Name/Dosage.

What is the Patient's current level of activity?

Are there any current activity limitations/restrictions like driving, LIMDU profiles, etc.? Yes No

If Yes, please
elaborate: _____

—

Does the Patient currently use any equipment to assist with mobility or activities of daily living? Yes

No

If Yes, please
elaborate: _____

—

Are there any barriers to learning? Yes No If Yes, please elaborate:

Any cultural and/or dietary preferences? Yes

No

If Yes, please elaborate:

Travel Clearance for Veterans Only: Is the ***Veteran*** medically cleared for travel, individually, by one of the following modes of transportation? ***Car Bus Train Commercial Air***

Signature/Print Name of Referring Provider

Date: _____

Other

Comments: _____

Thank You!

Program Agreement

I am willing to be admitted to PREP for at least 1-3 weeks. However, depending upon your individualized evaluation/treatment plan, your length of stay may be shorter or longer in duration.

I agree to comprehensive evaluation including (but limited to): physiatrist, neurology, physical therapy, psychology specialists, psychiatry, neuropsychology, speech therapy, social work, occupational therapy, vocational therapy, vision, and/or audiology.

I agree to attend daily scheduled therapies. Routine absenteeism from scheduled therapies (without prior approval) may result in early discharge from the program. _____ **Initials**

I agree to attend weekly progress rounds, during which time treatment goals and progress will be addressed. This is your opportunity to participate directly in your medical care.

I agree to engage in scheduled social and physical activities specific to your individualized treatment plan (e.g., playing sports, aerobic exercise, yoga or dining out with other veterans/service members).

I agree to abstain from alcohol/illicit drugs, to abstain from non-prescribed drugs and to use prescribed medications as directed. You may be asked to provide a urine sample or take a breathalyzer for drug/alcohol screening at the team's request. **Note:** *Violation of this rule will deem you to be non-compliant, which will be reflected in your medical records.* _____
Initials

I agree, upon admission, to turn over ALL medications to the team nurse as hospital policy dictates. Patients are not allowed to manage/take their own medications while an inpatient. We reserve the right to search your room and/or belongings for medications in order to ensure your safety and the safety of others.

I agree to keep my treatment **CONFIDENTIAL** from other patients.

While you may be kept busy throughout the day, evenings and weekends are considered free time. We encourage you to use this time to continue to work on your treatment goals (e.g. completing assignments, exercising, socializing).

Evening and weekend passes are given at the discretion of your medical provider, but are ultimately a treatment team decision. Anytime you leave hospital grounds without staff you need a pass.

I understand that acts of physical or verbal violence against staff or other patients will not be tolerated and will result in immediate expulsion. I will treat each patient and team member with respect and will be treated with respect in turn.

Non-compliance with the above agreement and guidelines may lead to an early discharge.

I, _____, have been provided information regarding admission expectations and agree to abide by these patient agreement and guidelines.

Signature _____

Date _____

What to Expect and What to Bring

You have been referred to the James A. Haley VA Polytrauma Rehabilitation Center PREP Program. To prepare for your stay, please review the information below prior to travel.

Before you travel, please contact the PREP Program Case Manager, Sandra Dunaway, LCSW (813-972-2000 x 2924) to ensure accommodations are in order and we have your updated contact information.

Please be aware that you will be asked to do a urine drug test one admission and randomly throughout your stay.

As part of the admissions process you will be tested for COVID-19.

As part of the hospital policy you will be asked to wear a mask upon entering the hospital, when leaving your room, or when having close contact with other patients and providers.

As per hospital policy, all providers are required to wear a face shield as well as a mask during all patient interactions.

✓ Please bring the following items if applicable:

- Face mask
- Prescribed medications and/or vitamins
- Hearing aids
- Eyeglasses
- Braces/Splints
- Tens Unit/Alpha Stim
- CPAP machine
- Medical records (if you already have copies)
- DD214 (if available)
- Toiletries (soap, shampoo, shaving cream, deodorant, toothpaste, etc.)
- 1 weeks-worth of clothing to include Gym clothes, Swimsuit/trunks and sweater(s)
- Laundry facilities, detergent and fabric softener are provided for your convenience
- Sunglasses are allowed outdoors only
- Comfortable shoes (tennis shoes, play shoes) & shower shoes
- Please do not bring more than \$100 cash with you
- Personal identification (VA ID, Driver's License, Military ID)
- The following items are allowed: Laptop, IPAD, Cell Phone

✓ Items NOT to bring:

- Firearms and/or other supplies/weaponry
- Alcohol, illegal substances and/or mood-altering substances
- Chemical liquids (nail polish/nail polish remover)
- Glass items, including glass picture frames
- Non-prescribed medications (including creams, and over the counter medications)

Note: There may be other items that the staff deems inappropriate during treatment and is not responsible for lost or stolen items.

During admission:

- ✓ You will be admitted to the hospital for approximately three-four weeks. This length of stay may be extended or shortened as treatments are modified to each patient and their identified goals.
- ✓ You will be very busy with medical and mental health appointments, Monday through Friday from 8am to 4pm. Weekend and evening passes may be granted depending on your medical status.

Family Visitation: Family members are welcome to briefly visit our program. This is best accommodated either at initial admission or prior to discharge. Family meetings or telephone conferences can be scheduled to address ongoing treatment issues.