Mission Statement:
Our mission is to provide each service member with compassionate, state-of-the-art treatment services focusing on rehabilitation and mental health needs. Community reintegration and a comprehensive plan for restoration of function are paramount. Our goal is to assist in improving functional abilities, reduce symptom complaints, stabilizing psychological distress while restoring confidence and a sense of mastery, enhancing family relationships, and assisting veterans/service members with ongoing recovery.

Program Overview:
PREP is an inpatient rehabilitation program that specializes in the evaluation and treatment of complex reactions and symptoms associated with possible mild TBI and post-deployment adjustment difficulties. These unique programs encompass two phases:

PHASE I: Includes a 1-3 week comprehensive individualized evaluation to examine physical, cognitive, and mental health symptoms, and develop an individualized treatment plan.

PHASE II: Our treatment program provides intensive treatment for post deployment/combat related injuries encompassing both physical and mental health sequelae, including PTSD and other post-deployment readjustment issues. Treatment is collaborative and facilitated by an interdisciplinary team that can address both rehabilitation and mental health needs simultaneously.

Individualized treatment plans commonly include:

- Vestibular (balance) Rehabilitation
- Individual PTSD treatment (Prolonged Exposure)
- Cognitive Rehabilitation
- Recreation Therapy/Community Reintegration
- Relaxation Training / Yoga
- Post-deployment Adjustment Therapy
- Audiological Rehabilitation
- Pain / Headache Management
- Insomnia/ Sleep Apnea Treatment
- Physical Therapy / Core Strength Training
- Medical/ Medication Management
- Multisensory Evaluation/Treatment
- Vocational Rehabilitation
- Vision Therapy

For additional questions about the program please contact:
Telephone: (813) 972-2000 or Toll Free: (888) 716-7787

PREP POC at ext. 3415
Email: carlos.rivera5@va.gov

Admission Coordinator at ext. 6149
Email: Debbie.Shepherd@va.gov

PREP MIL 03/2016
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.
- 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 deemed you to be non-compliant which will be reflected in your medical records.**
- 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

PREP MIL 03/2016
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: ____________________________

<table>
<thead>
<tr>
<th>Service Member Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Member SSN#:</td>
</tr>
<tr>
<td>Service Member DOB:</td>
</tr>
<tr>
<td>Service Member Address:</td>
</tr>
<tr>
<td>City/State/Zip:</td>
</tr>
<tr>
<td>Service Member Phone #:</td>
</tr>
<tr>
<td>Service Member email:</td>
</tr>
</tbody>
</table>
SERVICE MEMBER DEMOGRAPHICS

Military Status:  □ Active Duty  □ Reserves  □ National Guard

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

Rank: ___________

Marital Status:  □ Never Married  □ Married  □ Domestic Partner  □ Separated
□ Divorced  □ Widowed

Gender:  □ Male  □ Female

What is the patient’s preferred language for discussing health care: ______________________

Does the patient currently utilize a Personal Health Information (PHI) system? (How do they manage their medical care and records?)  □ Yes  □ No

MEB process initiated?  □ Yes  □ No

If Yes, What is the current status?

________________________________________________________________________

________________________________________________________________________

Are there pending or history of military/civilian legal issues (Investigations, Line of Duty, arrests, etc)?

________________________________________________________________________

________________________________________________________________________

MEDICAL

Purpose of the referral to PREP?

________________________________________________________________________

________________________________________________________________________

Is the patient willing and able to fully participate in the program?

________________________________________________________________________

________________________________________________________________________

Date and Mechanism of Injury: _____________________________

________________________________________________________________________

________________________________________________________________________

PREP MIL 03/2016
Any admissions/hospital stays within the past 60 days (Psychiatric/Medical):

________________________________________________________________________

________________________________________________________________________

What is the patient’s current medication list?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

What is the patient’s current level of activity:

________________________________________________________________________

________________________________________________________________________

Does the patient currently use any equipment to assist with mobility or activities of daily living?  □ Yes  □ No  If yes,  ____________________________________________

________________________________________________________________________

Are there any current activity limitations and restrictions? (Driving, limited duty profiles, etc.):

________________________________________________________________________

________________________________________________________________________

Are there any barriers to learning?  __________________________________________

________________________________________________________________________

Are there any cultural and/or dietary preferences of the patient?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Other Comments:  _________________________________________________________

________________________________________________________________________

________________________________________________________________________
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 to ensure accommodations are in order and we have your updated contact information.

✔ Please bring the following items if applicable:
  - Prescribed medications and/or vitamins
  - Hearing aids
  - Eye glasses
  - 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, Swim suit/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.
The following medical documents, if available, must be included as part of the referral packet or when requested by Medical Director. Please send documents in a secured electronic format (secured email or fax).

**Neuropsychology:**
Neuropsychology Report

**Physical Therapy:**
Physical Therapy Discharge Summary or most recent re-assessment notes
Recent Orthopedic assessments and imaging reports
Vestibular testing Audiograms, VNG testing

**Mental Health:**
Psychology and/or Psychiatric Notes

**Speech Pathology / Occupational Therapy:**
Discharge Summary
Initial Evaluation and/or testing

**General Reports/Notes:**
Current/Reconciled Medication List
Vision/Optometry Notes
Audiology Evaluations
Electronystagmogram / Electromyogram
Radiology Reports (MRI, CT-Scan, Ultrasounds, Echocardiogram, Plain X-Ray reports)

**Any Special Consults/Procedures:**
Endoscopy/Colonoscopy
Renal
Endocrine

---

**PREP Packet Completion Checklist**

Use this checklist to ensure referral packet is complete before submission. Incomplete **Referrals will be discontinued after 30 calendar days if missing documents are not received.**

- ______ Printed name, initialed/signed and dated PREP Patient Agreement
- ______ Completely filled out and dated PREP Referral Form, with Referring Clinician (MD, NP, and PA) and Referring Social Worker/Case Manager contact information.
- ______ Complete PREP Packet (provide as much information as possible and document N/A if not applicable)
- ______ Completely filled out and signed Military Treatment Facility Referral Form to VA Liaison (MTF) Referral Form, VA Form 10-0454
- ______ Completely filled out, signed and dated Acknowledgement of the Notice of Privacy Practice, VA Form 10-0483
- ______ Medical Records:
  - Medical documentation of TBI or events/symptoms leading to TBI suspicion (initial documentation and follow up notes/treatments within past 6 months)
  - Current Level of Functioning (current within past 6 months)
  - Current Medication List
  - Other Documents (per above list of documents)

PREP MIL 03/2016
**MILITARY TREATMENT FACILITY REFERRAL FORM TO VA LIAISON**

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

MTF Referral Source

Military Social Worker/Case Manager (If different than referral source)

VA Liaison for Health Care

**PATIENT PERSONAL INFORMATION**

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Middle Name</th>
<th>Suffix</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Full SSN</th>
<th>Home Phone Number</th>
<th>Cell Phone Number</th>
</tr>
</thead>
</table>

Complete Home Address (City & State & Zip)

<table>
<thead>
<tr>
<th>County</th>
<th>Email Address</th>
<th>DOB</th>
<th>Mother’s Maiden Name</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Age</th>
<th>Religion</th>
<th>Marital Status</th>
<th>Place of Birth (City&amp;State&amp;Zip)</th>
</tr>
</thead>
</table>

Gender [ ] Male  [ ] Female  Is the patient Spanish, Hispanic, or Latino: [ ] Yes  [ ] No

What is Patient’s Race? (You may check more than one.)

- [ ] American Indian or Alaska Native
- [ ] Asian
- [ ] Black or African American
- [ ] Native Hawaiian or Other Pacific Islander
- [ ] White

<table>
<thead>
<tr>
<th>Father’s Name</th>
<th>Mother’s Name</th>
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</thead>
</table>

**EMERGENCY CONTACT**

- [ ] Next-of-Kin
- [ ] Family
- [ ] Durable Power of Attorney for Health Care

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship</th>
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</table>

Complete Address & City & State & Zip

<table>
<thead>
<tr>
<th>Home Phone Number</th>
<th>Cell Phone Number</th>
</tr>
</thead>
</table>

Does the Patient have an Advance Directive?

[ ] Yes  [ ] No

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

<table>
<thead>
<tr>
<th>Branch of Military</th>
<th>[ ] Army  [ ] Air Force  [ ] Navy  [ ] Marine Corps  [ ] Coast Guard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Component</td>
<td>[ ] National Guard  [ ] Reserve  [ ] Active</td>
</tr>
<tr>
<td>Service Status</td>
<td>[ ] Active Duty (currently)  [ ] Retired - Date of retirement</td>
</tr>
<tr>
<td>Service Entry Date</td>
<td>ETS</td>
</tr>
<tr>
<td>Combat Dates &amp; Theater (locations)</td>
<td>Release from Active Duty</td>
</tr>
</tbody>
</table>

Parent Command & POC & Phone Number

In process of discharge:

- [ ] FTS
- [ ] MER
- [ ] Limited Duty
- [ ] Admin Sep
- [ ] Other

Anticipated date of separation (if known): Status of MEB/PEB:

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

Date of injury:  

<table>
<thead>
<tr>
<th></th>
<th>BI</th>
<th>NBI</th>
<th>Disease/ Disorder</th>
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</thead>
</table>

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 returning 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:  

VA FORM 10-0454 MAR 2009  Page 2 of 3
REFERRALS TO POLYTRAUMA WILL NEED TO INCLUDE THE FOLLOWING:

- History & Physical
- Notes from theater, Germany, Medivac flight note, etc.
- MD progress notes. If pt has fractures include ortho note w/ weight bearing status & any other restrictions.
- Include notes from Specialty Services i.e. neurosurgery, neurology, ID, plastics, ophthalmology
- Current lab work: CBC, comprehensive metabolic panel, urinalysis, and others as appropriate (i.e. INR, arterial blood gases, etc)
- Cumulative microbiology results
- Cumulative results of cerebrospinal and any other fluid analysis (i.e. pleural, ascitic, synovial, etc.)
- Current medications
- Radiology reports for CT scans, MRI's, ultrasounds, vascular studies, special procedures, angiograms & list of radiology studies performed
- OR notes (especially regarding all implanted devices such as pegs, trachs, stents, filters, etc.)
- Recent therapy notes from OT, PT, & SLP
- Neuropsychology testing performed
- Social Work psychosocial assessment
- Interim summary describing the hospital course and complications to date
<table>
<thead>
<tr>
<th><strong>Acknowledgement of the Notice of Privacy Practices</strong></th>
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</thead>
<tbody>
<tr>
<td>Acknowledgement of Department of Veterans Affairs, Veterans Health Administration (VHA) Notice of Privacy Practices</td>
</tr>
<tr>
<td>The signature below only acknowledges receipt of the VHA Notice of Privacy Practices, effective date 23 September 2013.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Signature of Patient/Patient Representative</th>
<th>Date</th>
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<tbody>
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<table>
<thead>
<tr>
<th>Name of Patient/Representative</th>
<th>Relationship to patient (if applicable)</th>
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<table>
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<tr>
<th>Last four SSN</th>
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[VA FORM] 10-0483
JUL 2015
Adobe Forms Designer