Department of Veterans Affairs

COMMUNITY CARE PROVIDER - REQUEST FOR SERVICE

(Separate Form Required for Each Service Requested)

If care is needed within 48 hours or if Veteran is at risk for Suicide/Homicide, please call the VA directly. *Indicates a required field

NOTE: Requests are approved/denied at VA Medical Center's discretion and supporting documentation must accompany each request.

VA FACILITY NAME:	VA FACILITY LOCATION:	*VA AUTHORIZATION/ REFERRAL NUMBER	TODAY'S DATE *(mm/dd/yyyy)*:

VETERAN INFORMATION

*VETERAN'S NAME *(Last, First, MI)*	*DATE OF BIRTH *(mm/dd/yyyy)*:

ORDERING PROVIDER INFORMATION

*ORDERING PROVIDERS NAME:	*ORDERING PROVIDERS NPI:	*ORDERING PROVIDERS 24-HR EMERGENCY CONTACT NUMBER *(for abnormal/critical findings)*:
*ORDERING PROVIDERS OFFICE PHONE:	*ORDERING PROVIDERS FAX NUMBER:	*ORDERING PROVIDERS SECURE EMAIL ADDRESS:

REQUESTED SERVICE - ONE SERVICE PER FORM

NEW REQUEST: **(Each request must be entered on a separate form)*

- ☐ PRIMARY CARE — PROCEDURE:
- ☐ SPECIALTY CARE
- ☐ MENTAL HEALTH — ICD 10:
- ☐ DURABLE MEDICAL EQUIPMENT *(DME) (Please enter information on Page 2)*
- ☐ LABORATORY/RADIOLOGY

ADDITIONAL REQUESTS WITH CURRENT PROVIDER:

- ☐ ADDITIONAL TIME WITH CURRENT PROVIDER
- ☐ ADDITIONAL VISITS WITH CURRENT PROVIDER

SERVICE TYPE *(Select one)*:

- ☐ DIAGNOSTIC TEST
- ☐ RADIOLOGY
- ☐ VISITS

ADDITIONAL INFORMATION:

VETERAN PREFERRED LOCATION OF SERVICE *(Location Name)*:

- ☐ VA FACILITY _____
- ☐ COMMUNITY FACILITY _____
- ☐ COMMUNITY PROVIDER _____
- ☐ NO PREFERENCE _____

***ATTESTATION:**

I do hereby attest that the forgoing information is true, accurate, and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to administrative, civil, or criminal liability.

I do hereby acknowledge that VA reserves the right to perform the requested service(s) if the following criteria are met: (1) The patient agrees to receive services from VA (2) Service(s) are available at VA facility and are able to be provided by the clinically indicated date (3) It is determined to be within the patients best interest. Upon completion of the requested service(s), VA will provide all resulting medical documentation to the ordering provider. If all criteria listed are not true and VA agrees the service(s) are clinically indicated, VA will provide a referral for services to be performed in the community.

I do hereby attest that upon receipt of order/consult results, I will assume responsibility for reviewing said results, addressing significant findings, and providing continued care.

*PROVIDER SIGNATURE:	*DATE *(mm/dd/yyyy)*:

DURABLE MEDICAL EQUIPMENT (DME) AND PROSTHETICS

*****REQUIRED INFORMATION FOR ALL DME AND PROSTHETIC REQUESTS**

Please see https://www.va.gov/COMMUNITYCARE/providers/Service_Requirements.asp for URGENT DME requests.

NOTE: Failure to thoroughly complete the RFS for DME will result in delayed patient care and prevent the VA from DME fulfillment.

DME AND PROSTHETICS INFORMATION

*HCPCS FOR THE ITEM(S) BEING PRESCRIBED:	*BRAND, MAKE, MODEL, PART NUMBERS:	*MEASUREMENTS:

*QUANTITY: *ICD 10:

*PROVISIONAL DIAGNOSIS:

*DELIVERY AND/OR PICKUP OPTIONS:

- ☐ DELIVER TO ORDERING PROVIDERS ADDRESS
- ☐ DELIVER TO VETERANS HOME
- ☐ VETERAN WILL PICK UP AT THE VA MEDICAL CENTER
- ☐ DELIVER TO COMMUNITY VENDOR FOR DELIVERY AND SET UP OF DME

DURABLE MEDICAL EQUIPMENT (DME) EDUCATION AND TRAINING

EDUCATION, TRAINING, AND/OR FITTING:

☐ WAS COMPLETED ☐ WAS NOT COMPLETED

**Education, training, and/or fitting of DME must be completed before DME is issued or mailed to Veteran. If not completed, DME will be mailed to requesting provider's address.*

REQUESTING PROVIDER'S ADDRESS:

MEDICAL JUSTIFICATION FOR THE DME

HOME OXYGEN INFORMATION

PA02 AT REST:	02SAT AT REST:	OXYGEN FLOW RATE:	EXTENT OF SUPPORT *(Continuous, Intermittent, Specific Activity):*

OXYGEN EQUIPMENT *(Stationary/Portable):*	DELIVERY SYSTEM *(Cannula, Mask, Other):*

THERAPEUTIC FOOTWEAR ASSESSMENT INFORMATION

Prescription for therapeutic footwear for severe or gross foot deformity which cannot be accommodated with conventional footwear.

Fill out the applicable information below:

☐ LEFT FOOT ☐ RIGHT FOOT ☐ BILATERAL

☐ PREFABRICATED THERAPEUTIC FOOTWEAR

☐ CUSTOM THERAPEUTIC FOOTWEAR

DESCRIBE FOOT DEFORMITY:

NOTE: Only patients who are experiencing medical conditions noted in the risk scores can be prescribed therapeutic/diabetic footwear.

Prescription for prefabricated therapeutic footwear due to disease pathology resulting in neuropathy or peripheral artery disease.

Check appropriate diabetic/amputation risk score below:

☐ **Risk Score 2**: patient demonstrated sensory loss (inability to perceive the Semmes-Weinstein 5.07 monofilament), diminished circulation as evidenced by absent or weakly palpable pulses, foot deformity, or minor foot infection, and a diagnosis of diabetes.

☐ **Risk Score 3**: patient demonstrated peripheral neuropathy with sensory loss (i.e., inability to perceive the Semmes-Weinstein 5.07 monofilament), and diminished circulation, and foot deformity, or minor foot infection and a diagnosis of diabetes, or any of the following by itself: (1) Prior ulcer, osteomyelitis or history of prior amputation; (2) Severe Peripheral Vascular Disease (PVD) (intermittent claudication, dependent rubor with pallor on elevation, or critical limb ischemia manifested by rest pain, ulceration or gangrene); (3) Charcot's joint disease with foot deformity; and (4) End Stage Renal Disease.

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*PROVIDER SIGNATURE:	*DATE *(mm/dd/yyyy)*: