MILITARY HISTORY CHECKLIST

PATIENT DATA	Completed By:	
Patient's Name:		Date:
Address:	Hospice Medical Record #:	Last 4 SSN:

VETERAN STATUS INFORMATION

1. Say "THANK YOU FOR YOUR SERVICE" to build trust.

2. Did you (or your spouse or family member) serve in the military?

2a. Patient ☐Yes ☐No	Did you serve on active duty? ☐Yes ☐No Did your service include combat, dangerous or traumatic assignments? ☐Yes ☐No Do you have a copy of your DD214 discharge papers? ☐Yes ☐No

2b. Did your spouse serve on active duty? ☐Yes ☐No ☐N/A
Comments:

2c. Do you have any immediate family members that served or are serving in the military? ☐Yes ☐No
Comments:

MILITARY BACKGROUND

3. In which branch of the military did you serve?

☐ Army	☐ Space Force	☐ Merchant Marines during WWII
☐ Navy	☐ Coast Guard	☐ NOAA Commissioned Officer Corps
☐ Air Force	☐ National Guard	☐ Foreign Military Service
☐ Marines	☐ Army Reservist	• Country/Branch/Rank/Conflict_____

4. Which war era or period of service did you serve?

☐ WWII (12/7/41 to 12/31/46) ☐ Korea (6/27/50 to 1/31/55) ☐ Cold War ☐ Vietnam (2/28/61 – 5/7/75 if served in Vietnam; 8/5/64 – 5/7/75 otherwise) *Note: VA also recognizes 11/1/55 – 8/4/64 for in-country service.*	☐ Gulf War (8/2/90 – 11/11/98) ☐ Peace Time ☐ Operation Iraqi Freedom/Operation Enduring Freedom (OIF/OEF) ☐ Other Note: After 9/7/80, must have completed 24 months continuous active service, or the full period for which they were called or ordered to active duty.

5. When did you serve? (MM/YYYY)
- Start Date:
- End Date:

6. What was your rate/duty/occupation in the military?

7. Overall, how do you view your experience in the military?

8. If available, would you like someone on your care team to have military experience?
☐ Yes ☐ No ☐ Indifferent

VA BENEFITS INFORMATION

9. Are you enrolled in VA? ☐Yes ☐No ☐Unsure

8a. Do you receive any VA benefits? ☐ Yes ☐ No

8b. Do you have a service-related injury or disease? ☐ Yes ☐ No

MILITARY HISTORY CHECKLIST

• Condition covered by service-connection_____ • Percentage of service-connected disability _____
8c. Do you get your medications from VA? ☐ Yes ☐ No
8d. What is the name of your VA hospital or clinic?
8e. What is the name and contact information of your VA physician or Primary Care Provider?
8f. Would you like to talk with someone about benefits you or your family might be eligible to receive? ☐Yes ☐ No *Have VSO (veteran service officer) or POC in place should the answer be "yes"*.
VETERAN RECOGNITION
9. Would you be interested in having a volunteer offer you a Pinning Ceremony? ☐Yes ☐ No