משרד הביטחון
אגף משפחות , הנצחה ומורשת

מדינת ישראל

Israeli Representation Abroad

Attn: The Attending Physician / Attending Nurse

The fields marked with * are required.	
Date	
File Number	
Responsible representation	

This document is invalid unless accompanied by medical documentation in accordance with the requirements noted for each section.

Please complete all of the sections in English and in clear handwriting, and include the signature and stamp of the attending physician / attending nurse.

Form for Determination of the Provision of Nursing Care and Institutional Accommodations

We would appreciate your filling out this form for determination of the monthly quota of nursing care hours.

Applicant Personal Details

First Name *	Last Name *	Israeli ID / Passport Number[1]*
Address *	City *	Country *

Current Medical Diagnosis[2]

[1] If there is no Israeli identity card, enter a passport number.

[2] A computerized summary of the applicant's medical history must also be attached

Movement

☐ Walks independently	☐ With assistance
☐ With the aid of an instrument specify: ☐ A cane ☐ Walker ☐ A wheelchair ☐ Bedridden	

Dressing

☐ Independent ☐ Partial assistance ☐ Full assistance

Bathing

☐ Independent ☐ Partial assistance ☐ Full assistance

Eating

☐ Eats unassisted (independently)	☐ Partial assistance (preparation / serving / encouragement)
☐ Full assistance	

Vision

Attach a certificate confirming blindness / visual impairment (eligible applicants up to the age of 75), or a medical summary from an ophthalmologist / general practitioner indicating the state of the applicant's sight (eligible applicants over the age of 75)

☐ Normal	☐ Normal with glasses	☐ Blind in one eye
☐ Visually impaired	☐ Blind	

Bowel and Bladder Control

Bowel

☐ Full control ☐Partial control ☐ No control

Bladder

☐ Full control ☐Partial control ☐ No control

Use of absorbent products

☐ Yes ☐ No

Supervision due to Dementia / Mental State[3]
☐ Mild impairment of orientation and / or memory and / or mental state Requires partial supervision by another person, but may be left alone for short periods of time
☐ Significant impairment in orientation and / or memory and / or mental state. Requires the constant supervision (presence) of another person. Presents a danger to him/herself or to others when left alone
☐ Advanced dementia

Estimated Time to Recovery	
☐ Up to 3 months	☐ Up to 6 months
☐ Up to one year	☐ Permanent condition

1. Summary and Functional Evaluation [4]		
☐ Frail	☐ Emotionally frail	☐ Bedridden and in need of assistance
☐ Requires nursing care		☐ Requires complex nursing care
☐ Independent but in need of assistance		☐ completely independent

[3] Under the age of 80 - Diagnosis by a geriatric specialist / psychiatrist / neurologist is required.
*Over the age of 80 - 50% of the hours will be granted in the absence of a diagnosis. (See the hours chart - Appendix C of this directive)

[4] (Note the applicant's functional status according to the following categories)

2. The Main Functional Disabilities of the Patient

3. Recommendation

☐ Referral for a nursing home - based arrangement
☐ May remain at home and requires assistance at home

4. Living Accommodations

☐ Lives alone	☐ Lives with: Nurse's Name: _____

5. Physician's Details

Physician's name	Physician's stamp (with license number noted)
Signature	