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INITIAL ASSESSMENT

CASE MANAGEMENT DEPARTMENT

PATIENT IDENTIFICATION

Date of Assessment: _____ Referred by: <input type="checkbox"/> MD <input type="checkbox"/> Nursing <input type="checkbox"/> CMC/SW <input type="checkbox"/> Other: _____	
Current Diagnosis(s): _____	
Payor Source: Prim: _____ Sec.: _____ Other: _____	
MARITAL STATUS: Age _____ Prim Contact/Decision Maker: _____	
<input type="checkbox"/> M <input type="checkbox"/> S <input type="checkbox"/> E <input type="checkbox"/> W <input type="checkbox"/> D Relationship: _____ Phone #: _____	
Advanced Directive: <input type="checkbox"/> Y <input type="checkbox"/> N Copy Obtained: <input type="checkbox"/> Y <input type="checkbox"/> N Comment: _____	
Power of Attorney: <input type="checkbox"/> Y <input type="checkbox"/> N If yes, Name: _____ Phone #: _____	
Prior Mental Status: <input type="checkbox"/> Alert/Oriented to: <input type="checkbox"/> person <input type="checkbox"/> place <input type="checkbox"/> time <input type="checkbox"/> Confused <input type="checkbox"/> Forgetful <input type="checkbox"/> Lethargic/comatose <input type="checkbox"/> Cognitive Deficit: _____ <input type="checkbox"/> Unknown	Current Mental Status: <input type="checkbox"/> Alert/Oriented to: <input type="checkbox"/> person <input type="checkbox"/> place <input type="checkbox"/> time <input type="checkbox"/> Confused <input type="checkbox"/> Forgetful <input type="checkbox"/> Lethargic/comatose <input type="checkbox"/> Cognitive Deficit: _____ <input type="checkbox"/> Unknown
Emotional State: <input type="checkbox"/> Coping Appropriately <input type="checkbox"/> Other: _____	
Living Situation / Environment: <input type="checkbox"/> Lives alone <input type="checkbox"/> with spouse <input type="checkbox"/> with family <input type="checkbox"/> SNF (long term) bed hold expires: _____	Home Type: <input type="checkbox"/> Single Family <input type="checkbox"/> Multi-Family <input type="checkbox"/> Sr. Housing <input type="checkbox"/> Apt Levels:# _____ Stairs:# _____ <input type="checkbox"/> Elevator <input type="checkbox"/> W/C Ramp Other: _____
Financial Status: <input type="checkbox"/> Able to meet monthly expenses <input type="checkbox"/> Other: _____	
Previous Home Care Services: Agency: _____ Service(s) Received: _____	Formal & Informal Support System: _____
Prior Level of Function: Ambulation: <input type="checkbox"/> Independent <input type="checkbox"/> Assistance with _____ <input type="checkbox"/> Dependent / Bed bound Personal Care / ADLs / IADLs: <input type="checkbox"/> Independent <input type="checkbox"/> Assistance with _____ <input type="checkbox"/> Dependent / Bed bound	Current Level of Function: Ambulation: <input type="checkbox"/> Independent <input type="checkbox"/> Assistance with _____ <input type="checkbox"/> Dependent / Bed bound Personal Care / ADLs / IADLs: <input type="checkbox"/> Independent <input type="checkbox"/> Assistance with _____ <input type="checkbox"/> Dependent / Bed bound
D/C Plan: <input type="checkbox"/> Return home, no services; <input type="checkbox"/> Services to be determined <input checked="" type="checkbox"/> Home care: <input type="checkbox"/> New referral <input type="checkbox"/> Re-Referral <input checked="" type="checkbox"/> Return to nursing facility <input type="checkbox"/> Rehab <input type="checkbox"/> NH <input type="checkbox"/> New SNF <input type="checkbox"/> Placement <input type="checkbox"/> ST <input type="checkbox"/> LT <input type="checkbox"/> Acute Rehabilitation <input type="checkbox"/> Refer to Shelter <input type="checkbox"/> Refer to Substance Abuse	(D/C plan cont.) <input checked="" type="checkbox"/> Refer to: <input type="checkbox"/> APS <input type="checkbox"/> CPS <input type="checkbox"/> Refer to Psychiatry / Substance Abuse <input type="checkbox"/> Refer to Palliative Care Services <input type="checkbox"/> Refer to Guardianship <input type="checkbox"/> Refer to Financial Assistance <input type="checkbox"/> Refer to Meals-on-Wheels <input type="checkbox"/> Refer to other community services: _____
* D/C Plan: Discussed with: <input type="checkbox"/> Pt. * <input type="checkbox"/> Family * <input type="checkbox"/> S/O Understood: <input type="checkbox"/> Fully * <input type="checkbox"/> Partially * <input type="checkbox"/> None	
Barrier's to Discharge: _____	
Comments: _____	
RN / SW Signature / Title / Beeper #: _____ Date: _____	

DO NOT THIN

PART OF THE MEDICAL RECORD