Your Hospital's Logo Here

INITIAL ASSESSMENT

CASE MANAGEMENT DEPARTMENT

PATIENT IDENTIFICATION

Date of Assessment: _____ Referred by: ☐ MD ☐ Nursing ☐ CMC/SW ☐ Other: _____

Current Diagnosis(s): _____

Payor Source: Prim: _____ Sec.: _____ Other: _____

MARITAL STATUS: **Age** _____ **Prim Contact/Decision Maker:** _____

☐ M ☐ S ☐ E ☐ W ☐ D Relationship: _____ Phone #: _____

Advanced Directive: ☐ Y ☐ N Copy Obtained: ☐ Y ☐ N Comment: _____

Power of Attorney: ☐ Y ☐ N If yes, Name: _____ Phone #: _____

Prior Mental Status:
☐ Alert/Oriented to: ☐ person ☐ place ☐ time
☐ Confused ☐ Forgetful ☐ Lethargic/comatose
☐ Cognitive Deficit: _____
☐ Unknown

Current Mental Status:
☐ Alert/Oriented to: ☐ person ☐ place ☐ time
☐ Confused ☐ Forgetful ☐ Lethargic/comatose
☐ Cognitive Deficit: _____
☐ Unknown

Emotional State: ☐ Coping Appropriately ☐ Other: _____

Living Situation / Environment:
☐ Lives alone ☐ with spouse ☐ with family
☐ SNF (long term) bed hold expires: _____

Home Type:
☐ Single Family ☐ Multi-Family ☐ Sr. Housing
☐ Apt Levels:# _____ Stairs:# _____ ☐ Elevator
☐ W/C Ramp Other: _____

Financial Status: ☐ Able to meet monthly expenses ☐ Other: _____

Previous Home Care Services:
Agency: _____
Service(s) Received: _____

Formal & Informal Support System:

Prior Level of Function:
Ambulation:
☐ Independent
☐ Assistance with _____
☐ Dependent / Bed bound
Personal Care / ADLs / IADLs:
☐ Independent
☐ Assistance with _____
☐ Dependent / Bed bound

Current Level of Function:
Ambulation:
☐ Independent
☐ Assistance with _____
☐ Dependent / Bed bound
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☐ Independent
☐ Assistance with _____
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D/C Plan:
☐ Return home, no services; ☐ Services to be determined
■ Home care: ☐ New referral ☐ Re-Referral
■ Return to nursing facility ☐ Rehab ☐ NH
☐ New SNF ☐ Placement ☐ ST ☐ LT
☐ Acute Rehabilitation
☐ Refer to Shelter
☐ Refer to Substance Abuse

(D/C plan cont.)
■ Refer to: ☐ APS ☐ CPS
☐ Refer to Psychiatry / Substance Abuse
☐ Refer to Palliative Care Services
☐ Refer to Guardianship
☐ Refer to Financial Assistance
☐ Refer to Meals-on-Wheels
☐ Refer to other community services: _____

*** D/C Plan:** Discussed with: ☐ Pt. * ☐ Family * ☐ S/O Understood: ☐ Fully * ☐ Partially * ☐ None

Barrier's to Discharge: _____

Comments: _____

RN / SW Signature / Title / Beeper #: _____ Date: _____

DO NOT THIN

PART OF THE MEDICAL RECORD