Your Hospital's Logo Here

EMERGENCY DEPT OUTPATIENT SVCS ASSESSMENT

CASE MANAGEMENT DEPARTMENT

PATIENT IDENTIFICATION

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

Diagnosis(s): ____________

Payor Source: Prim: ____________ Sec.: ____________ Other: ____________

# of ED visits / Hospitalizations within last 6 months: ____________

MARITAL STATUS: **Age** ______ **Prim Contact/Decision Maker:** ____________

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

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

Advanced Directive: ☐ Y ☐ N Comment: ____________

Mental Status:
☐ Alert/Oriented to: ☐ person ☐ place ☐ time
☐ Confused ☐ Forgetful ☐ Lethargic/Comatose
☐ Cognitive Deficit: ____________
☐ Other: ____________

Emotional Status: ☐ Coping Appropriately
☐ Other: ____________

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

Level of Function:
Ambulation: ☐ Independent
☐ Assistance with ____________
☐ Dependent / Bed bound

Personal Care / ADLs / IADLs:
☐ Independent
☐ Assistance with ____________
☐ Dependent / Bed bound

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

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

Home Care Services:
Agency: ____________
Service(s) Received: ____________

Support System / Community Resources: ____________

D/C Plan:
☐ Return home, no services;
■ Home care: ☐ New referral ☐ Re-Referral
☐ Long term placement:
☐ Refer to Shelter
☐ Refer to Substance Abuse

■ Refer to: ☐ APS ☐ CPS
☐ Refer to Psychiatry
☐ Refer to Financial Assistance
☐ Refer to Meals-on-Wheels
☐ Refer to Community Case Management
☐ Refer to other Community Services: ____________

Plan for next ED visit within 6 months: ____________

Educational Need(s):

*** 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