

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**