

CASE MANAGEMENT DISCHARGE PLANNING ASSESSMENT

DATE OF INITIAL REVIEW: _____

ADMITTING DIAGNOSIS: _____

ARRIVED FROM: HOME EMERGENCY ROOM MD OFFICE ACUTE CARE TRANSFER

LIVING SITUATION: HOME NURSING HOME ASSISTED LIVING FACILITY

NAME OF FACILITY: _____ FACILITY PHONE NUMBER: _____

EMERGENCY CONTACT (verify w/face sheet) _____

Advanced Directives:

ADVANCED DIRECTIVES QUESTIONNAIRE SHEET REVIEWED? YES NO N/A FOR PEDI (<18YRS.)

DOES THE PATIENT HAVE ANY OF THE FOLLOWING? ADVANCE DIRECTIVE HEALTH CARE SURROGATE

HEALTH CARE PROXY POWER OF ATTORNEY

IF PATIENT HAS ANY OF THE ABOVE, HAS A COPY BEEN PLACED ON THE CHART? YES NO

IF NO, HAS THE FAMILY/SIGNIFICANT OTHER BEEN REQUESTED TO PROVIDE A COPY? YES NO

NEEDS ASSESSMENT:

CHECK ALL THAT APPLY:

ADL PRIOR TO HOSPITALIZATION: SELF CARE PARTIAL CARE COMPLETE CARE

RECEIVE HELP AT HOME NO YES AGENCY PROVIDING & PHONE NUMBER: _____

IF YES, TYPE OF HELP/THERAPY PROVIDED AT HOME:

NURSING HOMEMAKER TRACHEOSTOMY RESPIRATORY THERAPY VENTILATOR

MEALS SPEECH THERAPY PHYSICAL THERAPY OCCUPATIONAL THERAPY

HAS DME/O₂ EQUIPMENT IN THE HOME? NO YES AGENCY PROVIDING & PHONE NUMBER: _____

IF YES, TYPE OF DME/O₂ EQUIPMENT: CRUTCHES WALKER BSC WHEELCHAIR

NEBULIZER OXYGEN OTHER: _____

OTHER THERAPIES PRIOR TO HOSPITALIZATION:

NONE DIALYSIS TUBE FEEDING (NG PEG G-TUBE) HYPERALIMENTATION (IPN)

MEDIPORT PICC LINE CHEMOTHERAPY RADIATION THERAPY GROSSHONG CATHETER

OTHER: _____

SUPPORT SYSTEM: FAMILY/FRIENDS & PHONE

NUMBER(S): _____

INSURANCE PROVIDER: _____

CONTACT PHONE NUMBER: _____

AUTHORIZATION NUMBER: _____

INITIAL DISCHARGE PLAN ON AMISSION: _____

IF UNABLE TO COMPLETE ANY PART OF THIS FORM, STATE REASON/DATE: _____

SIGNATURE OF CASE MANAGER COMPLETING: _____

CASE MANAGEMENT
DISCHARGE PLANNING ASSESSMENT

University Hospital

ADDRESSOGRAPH

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INSTRUCTION: May be used by all disciplines involved, for the documentation of Interdisciplinary Care Conferences and Discharge Planning. Please refer to the Interdisciplinary Teaching Record and Interdisciplinary Discharge Instructions for the documentation of patient and family education.

Discipline Codes:

N = Nursing

ST = Speech Therapy

Rad = Radiology

Oth = Other Discipline
(indicate) _____

Nutr = Food & Nutrition Service

Rcc = Recreational Therapy

Card = Cardiology

PT = Physical Therapy

R = Respiratory Therapy

Neuro = Neuro diagnostics

OT = Occupational Therapy

SW = Social Work Services

Rad X = Radiation Therapy

CR = Cardiac Rehab

CM = Case Management

DATE/TIME	DISCIPLINE	NOTES

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