Your Hospital's Logo Here

SOCIAL SERVICES ASSESSMENT

PATIENT IDENTIFICATION

ASSESSMENT TYPE: ☐ Subacute ☐ Long Term Care	RESIDENT NAME:	DOB:	AGE:	SEX: ☐ M ☐ F

MARITAL STATUS: ☐ Never Married ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

ETHNICITY: ☐ African American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Other: _____

OCCUPATION (Last Position):

EDUCATION (Highest Level Completed):

PRIMARY LANGUAGE: ☐ English ☐ Other: _____ ☐ Spanish

ADMITTED FROM:

PHYSICIAN:

HOME ADDRESS: *(Street)* *(City)* *(State)* *(Zip)*

PHONE:

ADMITTING DIAGNOSIS(ES):

MANAGEMENT OF FINANCES: ☐ Self ☐ Other: _____ ☐ Spouse

FINANCIAL RESOURCES SUFFICIENT TO MEET MONTHLY NEEDS ? ☐ Yes ☐ No

PRIMARY INSURANCE: *(Type)* *(Policy #)*

SECONDARY INSURANCE: *(Type)* *(Policy #)*

SOCIAL ENVIRONMENT

DWELLING TYPE: ☐ Apartment ☐ House: # of levels _____ ☐ Senior's Building ☐ Other: _____

DWELLING EASILY ACCESSIBLE ? ☐ Yes ☐ No

OF STAIRS TO ENTER DWELLING:

OF STAIRS INSIDE DWELLING:

LIVES WITH: ☐ Alone ☐ Other: _____ ☐ Spouse

SUPPORTIVE FAMILY ? ☐ Yes ☐ No ☐ N / A

SUPPORTIVE FRIENDS ? ☐ Yes ☐ No ☐ N / A

DAILY CONTACT w/ FAMILY / FRIENDS ? ☐ Yes ☐ No ☐ N / A

PRIMARY SUPPORT: *(Relation)* *(Phone #)*

PRIMARY SUPPORT HOME ADDRESS: *(Street)* *(City)* *(State)* *(Zip)*

NUMBER OF FAMILY MEMBERS:

Sons _____ Daughters _____ Grandchildren _____ Other _____

MENTAL HEALTH / COGNITION

HISTORY OF M.I. ? ☐ No ☐ Yes: _____

HISTORY OF M.R. ? ☐ No ☐ Yes: _____

ORIENTATION: ☐ Person ☐ Place ☐ Time

MEMORY FUNCTION: Short-term Impaired ? ☐ Yes ☐ No Long-term Impaired ? ☐ Yes ☐ No

LEVEL OF ALERTNESS: ☐ Alert ☐ Clouded ☐ Lethargic ☐ Unresponsive

EMOTIONAL STATE / STATUS: ☐ Coping Appropriately ☐ Other: _____

PART OF THE MEDICAL RECORD

RESIDENT'S FAITH & ACTIVITIES

RELIGIOUS AFFILIATION:

USUALLY ATTENDS RELIGIOUS SERVICES: ☐ Yes ☐ No

FINDS STRENGTH IN FAITH: ☐ Yes ☐ No

LEISURE INTERESTS: ☐ Reading ☐ Exercise ☐ Cards ☐ Other (describe below) ☐ Religious Activities ☐ Writing ☐ Trips / Travel ☐ Music _____

PERFORMS ACTIVITIES: ☐ Alone ☐ With Others ☐ Both

ALCOHOL / SMOKING

USES ALCOHOLIC BEVERAGES DAILY ? ☐ No ☐ Yes (describe) _____

USES TOBACCO PRODUCTS DAILY ? ☐ No ☐ Yes (describe) _____

ADVANCE DIRECTIVES

LIVING WILL ? ☐ Yes ☐ No

POA - HEALTHCARE ? ☐ Yes ☐ No

POA - FINANCES ? ☐ Yes ☐ No

POA - GENERAL ? ☐ Yes ☐ No

COPY OF DOCUMENT(S) ON CHART ? ☐ Yes ☐ No ☐ N / A

PERFORMS ACTIVITIES: ☐ Full Code ☐ Do Not Hospitalize ☐ DNR

DECISION MAKER:

GUARDIAN: ☐ N / A

PRIOR LEVEL OF FUNCTIONING

INDEPENDENT ? ☐ Yes ☐ No

RECEIVED HELP WITH: ☐ Meal Preparation ☐ Grooming ☐ Bathing ☐ Dressing ☐ Laundry ☐ Shopping ☐ N / A ☐ Other: _____

AVAILABLE EQUIPMENT DEVICES UTILIZED: ☐ Wheelchair ☐ 3 in 1 Commode ☐ Walker: _____ ☐ Corrective Lenses ☐ Shower Chair ☐ Hearing Aide ☐ Cane ☐ Other: _____

COMMUNITY RESOURCES UTILIZED: ☐ Adult Day Program ☐ Meals on Wheels ☐ Home Health Services ☐ Live-in Care Aide ☐ Other: _____

DISCHARGE STATUS / PLAN

DISCHARGE POTENTIAL: ☐ Excellent ☐ Good ☐ Fair ☐ Uncertain ☐ Marginal ☐ None

PROJECTED LENGTH OF STAY: ☐ Short Term ☐ Long Term ☐ Uncertain

RESIDENT PREFERENCE TO RETURN TO COMMUNITY: ☐ Yes ☐ Uncertain ☐ No

DISCHARGE LOCATION:

PROJECTED DISCHARGE NEEDS: ☐ HHS: _____ ☐ DME: _____ ☐ LTC ☐ Assisted Living ☐ Community Support: _____ ☐ Other: _____

DISCHARGE PLAN DISCUSSED WITH: ☐ Resident ☐ Family ☐ Responsible Party ☐ Other: _____

RESIDENT GOAL(S):

SOCIAL WORKER SIGNATURE: **SOCIAL WORKER'S TITLE:** **DATE:**

PART OF THE MEDICAL RECORD