Case Management Admission Assessment

Date of Admission _____

Patient Name _____

Room _____

Medical Record Number _____

Registration _____

Diagnosis _____

History _____

Language: ☐ English ☐ Other _____

Next of kin _____ Telephone Number _____

Advance directives _____

Patient able to make needs known ☐ Yes ☐ No

Referral Source

☐ Clinic _____ ☐ ED

☐ Private MD _____

☐ Long-term care facility _____

☐ Other _____

Can patient return: ☐ Yes ☐ No ☐ Unknown at this time

Insurance information

Primary _____ Contact _____

Secondary _____ Contact _____

Discharge service covered _____

Preferred provider _____

Medicaid eligible: ☐ Yes ☐ No ☐ Unknown

Referred date _____

Comments _____

_____

_____

Prior to admission

Living arragements _____

☐ Apartment/house: ☐ Elevator ☐ Stairs _____

Comments _____

☐ Nursing home

Bed hold ☐ Yes ☐ No ☐ Unknown

☐ Adult home ☐ Shelter ☐ Homeless ☐ Other

Comments _____

_____

Activities of daily living ☐ Dependent ☐ Independent

Assistive device ☐ Yes _____ type of device

☐ Dependent ☐ Independent

Supports

Informal ☐ Yes ☐ No Formal ☐ Yes ☐ No

Service(s) _____ Service(s) _____

Provider(s) ☐ Family ☐ Friend

Agency/vendor _____

Name _____

Referred ☐ Yes ☐ No Date _____

Telephone _____ Contact _____

Equipment in Home

☐ Yes ☐ No Vendor _____

☐ Oxygen ☐ Commode ☐ Assistive device ☐ Other

Does patient meet social work high-risk screens? ☐ Yes ☐ No

Referred to: _____ Date _____

Does patient meet home care screens? ☐ Yes ☐ No

Discharge plan: ☐ Same as prior to admission

☐ Unclear at present ☐ New plan

☐ Other _____

Continuing care resources _____

_____

Equipment Needed

☐ Same as prior to admission ☐ Unclear at present

☐ Other _____

Vendor _____ Date _____

Mode of transportation for discharge: ☐ None ☐ Auto

☐ Public ☐ Taxi/car service ☐ Ambulette

☐ Ambulance _____

Who will accompany patient? ☐ No one ☐ Family/friend

☐ Home attendant/home health aide

Name _____

Comments _____

Medical follow-up with: ☐ Clinic _____

☐ Other _____ Private MD _____

Does this patient have adequate financial supports for a safe discharge?

☐ Yes ☐ No _____

Acute hospital treatment plan: ☐ Discussed with MD

☐ Chart Review

Comments _____

_____

_____

Case Manager Name _____

Date _____

Signature _____