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 surface sheet)

Advanced Directives:

Advanced Directives Questionnaire Sheet Reviewed? ☐ YES ☐ NO ☐ N/A FOR PNH (<18yrs.)

Does the patient have any of the following?

☐ ADVANCE DIRECTIVE ☐ HEALTH CARE SURROGATE

Heath 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 ☐ HOME WATER ☐ TRACHOSTOMY ☐ 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 (TPN)

☐ MEDIPORT ☐ PICC LINE ☐ CHEMOTHERAPY ☐ RADIATION THERAPY ☐ GROSSING CANISTER

☐ OTHER:

Support System: FAMILY/FRIENDS & PHONE NUMBER(s):

__________________________________________

__________________________________________

__________________________________________

__________________________________________

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__________________________________________

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__________________________________________

__________________________________________

__________________________________________

Insurance Provider: ____________________________

Contact Phone Number: ____________________________ Authorization Number: ____________________________

Initial Discharge Plan on Admission:

__________________________________________

If unable to complete any part of this form, state reason/date:

__________________________________________

Signature of Case Manager Completing:

__________________________________________

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University Hospital
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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.

<table>
<thead>
<tr>
<th>Discipline Codes</th>
<th>ST = Speech Therapy</th>
<th>Rad = Radiology</th>
<th>Oth = Other Discipline (indicate)</th>
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<tbody>
<tr>
<td>N = Nursing</td>
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<tr>
<td>Nutr = Food &amp; Nutrition Service</td>
<td>Rec = Recreational Therapy</td>
<td>Card = Cardiology</td>
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<td>PT = Physical Therapy</td>
<td>R = Respiratory Therapy</td>
<td>Neuro = Neuro diagnostics</td>
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<tr>
<td>OT = Occupational Therapy</td>
<td>SW = Social Work Services</td>
<td>Rad X = Radiation Therapy</td>
<td>CM = Case Management</td>
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<tr>
<th>DATE/TIME</th>
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