McLaren FLINT

CASE MANAGEMENT
DISCHARGE NEEDS ASSESSMENT

To be completed by case manager or home care coordinator:

_____ Physician order for home care
_____ Skilled home care needs identified: _____
_____ Patient is homebound

Agency options discussed: _____
Patient family request VNA: _____
Patient/family request: _____

Date referred to VNA-Home Care: _____ / _____ / _____
Coordinator by: _____ Case Manager, Date: _____ / _____ / _____

S: Information Source: _____
Who will be assuming primary responsibility for care: _____
Relationship: _____ Phone: _____
Primary caregivers health is: ☐ Good ☐ Fair ☐ Poor
Knowledge of treatment required: ☐ Good ☐ Fair ☐ Poor
Pt. Lives:
☐ Parents ☐ Alone ☐ Spouse/S.O. ☐ Children ☐ ECF
☐ Group Home: _____ Contact Person: _____ Phone #: _____
☐ Other: _____
Patient Drives: ☐ Yes ☐ No, if no what method of transportation: _____
Floors at home: _____ Entry steps/ramp: _____
Bathroom on: _____ Bedroom on: _____
Level of activity prior to admission: _____
Who does the household chores: _____

Patient currently has the following services:
☐ Home health care: _____ Phone #: _____ ☐ RN ☐ Aide ☐ PT ☐ OT ☐ SS
☐ DME: _____ Phone #: _____ ☐ WC ☐ Commode ☐ O_2 ☐ Walker
☐ Meals on Wheels ☐ GAP ☐ Lifeline ☐ Visiting Physicians ☐ Cane ☐ Bed ☐ Other: _____
☐ Hospice: _____ Phone#: _____
☐ Aide program: _____ Phone#: _____

O: Patient age: _____ Diagnosis: _____ Sig. HX: _____
Patient LOC: ☐ Alert ☐ Oriented ☐ Confused ☐ Lethargic Prescription coverage: _____
Primary physician verification: _____ L & S: _____
Dialysis: _____ (days) / _____ times Dialysis facility: _____
Functional Limitation:
☐ Speech ☐ Paralysis ☐ Nutrition ☐ Hearing ☐ Decubiti ☐ Hygiene ☐ Respiratory
☐ Vision ☐ Amputation ☐ Cognition ☐ Sensation ☐ Mobility ☐ Elimination

A: May need upon discharge: Skilled treatment modalities anticipated upon discharge
☐ Wound care/drain care ☐ Med teaching ☐ Foley care ☐ Diabetic education ☐ IVABX ☐ Pulmonary monitoring
☐ Cardiac monitoring ☐ Ostomy care ☐ Labs ☐ Other: _____
☐ Home health care ☐ RN ☐ AIDE ☐ PT ☐ OT ☐ SW ☐ ST
☐ DME: _____ (list) _____
☐ Group home: _____ Cardiac rehab: _____ Diabetic classes: _____
☐ ECF ☐ LTAC ☐ Hospice ☐ Rehab ☐ SS (Abuse or neglect) ☐ Meals on Wheels
☐ Education: _____ Reason for: _____
☐ GAP ☐ Lifeline ☐ Aide program ☐ Psych ☐ Pulmonary rehab

P: Will: ☐ Discuss with Social Worker ☐ Provide patient with Home Health Services Provider List
☐ Discuss with doctor ☐ Verify insurance ☐ Will reevaluate in _____ days

Case Manager/Home Care Coordinator Signature: _____ **Date:** _____ / _____ / _____

PT.

MR.#/RM.

DR.