ALEGRE'S Home Health Care

SOCIAL SERVICE
DATA BASELINE

GENERAL INFORMATION

Patient Name _____ DOB: _____ Sex: _____

Patients MR# _____ HIC # _____ Age: _____

Diagnosis _____

_____

Prior Agency Admissions _____

Prior Referral to Social Services: Yes ____ No ____ If yes, but not seen explain: _____

_____

Reason for Present Referral to Social Service _____

_____

PATIENT PROFILE

Patient's Understanding of Reason for Referral _____

_____

Orientation: Time _____ Place _____ Pers _____ General Appearance _____

Place of Birth _____ Age came to U.S. _____

Emotional Tone _____ Motivation: Good _____ Poor _____ Guarded _____

Capacity to Cope with Present _____

Potential for Change- _____

FAMILY PROFILE / SOCIAL HISTORY

Marital Status S M W D # of Marriages _____ # of years _____

Children: _____

Address: _____

Significant Cult Mores _____

Communication bet Family _____

Patient and Family Knowledge _____

Household Members Health _____

Language _____ Religion _____ Importance _____

Living Arrangement _____ Condition _____

S/0 involved in Patients Care _____

Source of income _____ Monthly Income _____

Insurance _____ Unmet Needs _____

PERSON TO BE CONTACTED

Name _____ Address _____

Phone _____ Relation _____

AGENCIES NEEDED FOR PATIENT AND/OR FAMILY

Agency _____ Ph _____ Worker _____

Agency _____ Ph _____ Worker _____

Agency _____ Ph _____ Worker _____

Comment:: _____

_____

_____

Signature _____ Date _____

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ALEGRE'S Home Health Care

SOCIAL SERVICE NARRATIVE

PATIENT: _____ MR# _____ HIC # _____

PATIENT:

FAMILY:

DIAGNOSTIC IMPRESSIONS OF SOCIAL WORKER:

TREATMENT GOAL:
INCLUDE COMMUNITY AGENCIES TO BE UTILIZED

SIGNATURE: _____ DATE: _____

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MEDICAL SOCIAL SERVICES CARE PLAN

SOC DATE ____/____/____

REASON FOR VISIT/PROBLEM

MEDICAL SOCIAL SERVICES TREATMENT PLAN

PATIENT/CLIENT DESIRED OUTCOMES	SHORT TERM OUTCOMES Time Frame	LONG TERM OUTCOMES Time Frame

PLAN OF CARE

☐ Assessment of social and emotional factors (E1)	☐ Arrange transportation for medical appointments	☐ Services to family member(s)/caregiver(s)
☐ Counseling for long-range planning and decision making (E2)	☐ Emotional support to patient/client/family	☐ Referral to support group(s)/ community resource(s) (specify)
☐ Community resource planning (E3)	☐ Financial resource information	
☐ Short term therapy (E4)	☐ Arrangement of meal services	
☐ Identify eligibility for services/ benefits	☐ Initiate abuse reporting mechanism	
☐ Initiate counseling	☐ Initiate referral to personal emergency response system	
☐ Nursing home placement assistance	☐ Teach self-management skills	☐ Other:
☐ Alternate living arrangements	☐ Crisis intervention	

COMMENTS/ADDITIONAL INFORMATION

PATIENT/CLIENT/CAREGIVER RESPONSE TO PLAN OF CARE

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SUMMARY

GOALS ACHIEVED? ☐ Yes ☐ No
Specify

REFERRALS COMPLETED? ☐ Yes ☐ No
Specify

CARE COORDINATION: ☐ Care Manager, date ____/____/____
☐ Physician, date ____/____/____ ☐ Other (specify)

APPROXIMATE NEXT VISIT DATE ____/____/____
PLAN FOR NEXT VISIT

DISCHARGE DISCUSSED WITH: ☐ Patient/Client/ Family ☐ Care Manager ☐ Physician ☐ Other
DISCHARGE INSTRUCTIONS GIVEN TO PATIENT/CLIENT/ FAMILY? ☐ No ☐ Yes, specify

SIGNATURES/DATES

X ____/____/____
Patient Client/Caregiver (If applicable) *Date*

X ____/____/____
Medical Social Worker (signature/title) *Date*

PART 1 - Clinical Record | **PART 2 - MSS**

PATIENT/CLIENT NAME - Last, First, Middle Initial | ID#

MEDICAL SOCIAL SERVICES EVALUATION

DATE OF SERVICE ____/____/____

TIME IN _____ OUT _____

HOMEBOUND REASON: ☐ Needs assistance for all activities ☐ Residual weakness
☐ Requires assistance to ambulate ☐ Confusion, unable to go out of home alone
☐ Unable to safely leave home unassisted ☐ Severe SOB, SOB upon exertion
☐ Dependent upon adaptive device(s) ☐ Medical restrictions
☐ Other (specify) _____

TYPE OF EVALUATION
☐ Initial ☐ Interim ☐ Final
SOC DATE ____/____/____
(if Initial Evaluation, complete Medical Social Services Care Plan)

ORDERS FOR EVALUATION ONLY? ☐ Yes ☐ No If no, orders are _____

PERTINENT BACKGROUND INFORMATION

MEDICAL DIAGNOSIS/PROBLEM _____ **ONSET** ____/____/____

PRIOR LEVEL OF ADL STATUS _____

PRIOR PERTINENT MEDICAL/SOCIAL HISTORY _____

MEDICAL SOCIAL SERVICES ASSESSMENT

PSYCHOSOCIAL (Describe mental status, coping ability, attitude, safety prognosis and implications, etc.) _____

CURRENT LIVING SITUATION /SUPPORT SYSTEM (Describe relationships/communications/ interactions with family/caregiver/ significant other, etc.) _____

HEALTH FACTORS (Describe those factors that impede the POC from being effectively implemented, i.e., vision, hearing, nutrition, etc.) _____

ENVIRONMENTAL FACTORS (Describe those factors that impede the POC from being effectively implemented, i.e., transportation, safety, etc.) _____

FINANCIAL STATUS (Describe resources, income, assets/expenses, etc. that impede the POC from being effectively implemented.)

SIGNATURE/DATE

Complete TIME OUT (above) prior to signing below.

MEDICAL SOCIAL WORKER SIGNATURE/TITLE _____ **DATE** ____/____/____

PART 1 - Clinical Record PART 2 – MSW

PATIENT/CLIENT NAME - Last, First, Middle Initial | ID#

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ABANA HEALTH CARE, INC.

MEDICAL SOCIAL SERVICES REVISIT NOTE

DATE OF VISIT ____/____/____

TIME IN _____ TIME OUT _____

MEDICAL SOCIAL SERVICES

HOMEBOUND REASON: ❑ Needs assistance for all activities ❑ Residual weakness
❑ Requires assistance to ambulate ❑ Confusion, unable to go out of home alone
❑ Unable to safely leave home unassisted ❑ Severe SOB, SOB upon exertion
❑ Dependent upon adaptive device(s) ❑ Medical restrictions
❑ Other (specify) _____

REASON FOR VISIT/PROBLEM _____

ASSESSMENT/OBSERVATION (Current situation, i.e., psychosocial, physical condition, environment, etc.)

MEDICAL SOCIAL SERVICES INTERVENTIONS (if applicable, mark with "X".)

Assessment of social and emotional factors (EI)	Arrange transportation for medical appointments	Crisis intervention
Counseling for long-range planning and decision making (E2)	Emotional support to patient/family	Services to family member(s)/caregiver(s)
Community resource planning (E3)	Financial resource information	
Short-term therapy (E4)	Arrangement of meal services	Referral to support group(s)/ community resource(s) (specify)
Identify eligibility for services/benefits	Initiate abuse reporting mechanism	
Initiate counseling	Initiate referral to personal emergency response system	
Nursing home placement assistance	Teach self-management skills	
Alternate living arrangements	Pain Management	Other:

ANALYSIS OF FINDINGS/INTERVENTIONS/INSTRUCTIONS

EVALUATION AND PATIENT/CAREGIVER RESPONSE

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SUMMARY

GOALS ACHIEVED? ❑ Yes ❑ No
Specify _____

REFERRALS COMPLETED? ❑ Yes ❑ No
Specify _____

CARE COORDINATION: ❑ Care Manager, date ____/____/____
❑ Physician, date ____/____/____ ❑ Other (specify) _____

APPROXIMATE NEXT VISIT DATE ____/____/____

PLAN FOR NEXT VISIT _____

DISCHARGE DISCUSSED WITH: ❑ Patient/Family
❑ Care Manager ❑ Physician ❑ Other _____

DISCHARGE INSTRUCTIONS GIVEN TO PATIENT/FAMILY?
❑ No ❑ Yes, specify _____

SIGNATURES/DATES:

X _____ / / _____
Patient/Caregiver (if applicable) Date

X _____ / / _____
Medical Social Worker (Signature/title) Date

PART 1 - Clinical Record **PART 2 - MSS**

PATIENT NAME - Last, First, Middle Initial | ID#