MATRIX HOME CARE

MEDICAL SOCIAL WORK ASSESSMENT

Name of Responsible Person:	Relationship:	Phone:	PT/CL Name:	Date:
			Address:	
Person to Contact in Emergency:	Relationship:	Phone:	City, State, Zip:	
			Phone: D.O.B	Sex M F
Prior Medical Social Work Service			Referral Source/Date	
Frequency/Duration of Visit				
Rehabilitation Potential			Physician	Phone

	Diagnosis	Date of Onset	AGENCY/SNF:	Dates of Stay:
Primary				
Secondary			AGENCY/SNF:	Dates of Stay:

SPECIFIC INFORMATION DESIRED

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I. PERSONAL, PSYCHOSOCIAL AND FAMILY FUNCTIONING AND FINANCIAL INFORMATION:

A. HOUSEHOLD MEMBERS (names and relationships) | SIGNIFICANT OTHERS (names and relationships) | COMMENTS

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B. BEHAVIOR INDICATORS/PSYCHOSOCIAL FUNCTIONING.

Key PT = Patient
PCP = Primary Care Person

	GOOD PT PCP	FAIR PT PCP	POOR PT PCP	COMMENTS
Functional Ability				
Memory				
Comprehension				
Judgement/Decision Making				
Communciation Ability				
Knowledge of Health Problems				
Motivation to Resolve Needs				
Compliance with Treatment				
Ability to Accept Help				

C. **Significant psycho/social/emotional factors/needs for counseling:**

____

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Refer to Case Manager: ____________ Psych Nurse: ____________ MHMR: ____________ Other: ____________

Client/Designee: *I certify that the Matrix Home Cae Employee listed on this time slip worked the times indicated and the owrk was performed in a satisfavory manner. I agree to the times regarding this time slip.*

Employee Signature: ______________________

Patient/Client Signature: ______________________

PT/CL NAME: ______________________

ADDRESS: ______________________

CITY, STATE, ZIP: ______________________

VISIT DATE: ______________________

TIME IN: ____________ TIME OUT: ____________

Patient/Client Name: ______________________ Date: ______________

II. ASSESEMENT SUMMARY:

III. LONG-TERM CARE PLANNING:

- ______ Access community resourse utiliztion on ongoing basis
- ______ Provide information, referral consultation & collateral contacts as needed
- ______ Counsel/teach re: appropriate community resourse utilization
- ______ Instruct pt/family to call Care Team if assistance needed after discharge

IV.

Problem Areas/Reasons:

Indentify factors which are impeding patients ability to achieve maximal health potential/compliance with treatment plan.

HOUSING: Adequate YES NO

Due to: Crowing
Santitation
Structural deficiency
Neighborhood
Dysfunctional utilities

Other: ______________

EQUIPMENT/SUPPLIES/INFORMATION:

Adequate YES NO

Due to: Knowledge deficit
Income deficit

Other: ______________

INCOME:

Adequate YES NO

Due to: No income resource
Disproportionate living or medical expenses
Poor financial planning/ decision making

Other: ______________

SAFETY:

Adequate YES NO

Due to: Lack of supervision
Abuse/neglect
Poor judgement
Environment
Alcohol/substance abuse
Prome to falls or medical emergencies

Other: ______________

TRANSPORATION:

Adequate YES NO

Due to: Unable to drive
Unable to ride in car
Driver no available
Can't afford
Inaccessibility

Other: ______________

PERSONAL CARE/HOUSEKEEPING:

Adequate YES NO

Due to: Lives alone
Elderly/ill PCP
Extreme dependency of pt.
Employed PCP
Refuses to accept help
Cannot afford to hire

Other: ______________

FOOD MEALS:

Adequate YES NO

Due to: Pt/PCP unable to prepare meals
Inadequate income
Inability to shop for groceries

Other: ______________

OTHER: ______________

Comments: ______________

Signature: ______________ Date: ______________