Social Work Assessment

Demographic Information	
Date of Visit:	Patient's Name:
Social Worker:	Patient's Date of Birth:
Address:	Patient's Physician:

Environment and Safety			
Marital Status: ☐ Single	☐ Married	☐ Widow(er)	☐ Divorced
Who does the patient live with?			
Who is the patient's support person?			
Does the patient have community services?	☐ Yes Agency: _____ Services Provided: _____ Frequency: _____	☐ No Is the patient eligible for services? ☐ Yes ☐ No Was a referral made? ☐ Yes ☐ No	
Does the patient have a capable caregiver in the home?			☐ Yes ☐ No
Does the house have functional door locks?			☐ Yes ☐ No
Does the patient feel safe?			☐ Yes ☐ No
Does the patient have a security system and/or lifeline alert?			☐ Yes ☐ No
Are there any home environment issues that could affect the patient's health? (e.g., mold, lack of air conditioning or heat, lack of smoke detectors)			☐ Yes ☐ No
Are there safety issues? (e.g., broken furniture, rugs that present fall hazards)			☐ Yes ☐ No
Does the patient have a disability?			☐ Yes ☐ No
If yes, have accommodations been made for the disability?			☐ Yes ☐ No
Does the patient require durable medication equipment (DME) in the home?			☐ Yes ☐ No
Is the DME equipment in the home?			☐ Yes ☐ No
☐ Bedside Commode ☐ BiPAP* ☐ Cane ☐ CPAP**	☐ Electric Wheelchair ☐ Elevated Commode Seat ☐ Emergency Response System (ERS) ☐ Other: _____	☐ Hospital Bed ☐ Lift Chair ☐ Nebulizer ☐ Oxygen	☐ Shower Chair ☐ Walker ☐ Wheel Chair ☐ Rollator Walker
Identify the DME provider:			
Is the patient managing self-care at home?			☐ Yes ☐ No
Are there pets in the home?			☐ Yes ☐ No

* Bilevel positive airway pressure = BiPAP
**Continuous positive airway pressure = CPAP

Life Plan	
Does the patient have advance care directives?	☐ Yes ☐ No
Does the patient have do not resuscitate (DNR) orders?	☐ Yes ☐ No
Is the DNR paperwork at home?	☐ Yes ☐ No
Does the patient have a healthcare surrogate? Name: _____ Telephone: _____ Email: _____	☐ Yes ☐ No
What are the patient goals for treatment? (remain at home, reduce hospital stays, recover to previous functioning, etc.) _____ _____ _____	

Psychological	
Is the patient alert to time, place, and surrounding?	☐ Yes ☐ No
Is the patient aware of their physical condition and any limitations due to their condition?	☐ Yes ☐ No
Does the patient have any current stressors?	☐ Yes ☐ No
Does the patient have a history of mental illness? Treatment history: _____ _____ _____ _____	☐ Yes ☐ No
Does the patient express feelings of depression or anxiety?	☐ Yes ☐ No
Is the patient being treated for anxiety or depression?	☐ Yes ☐ No
Identify the provider responsible for treatment Name: _____	
Does the patient consume alcohol? How much? _____ How often? _____	☐ Yes ☐ No
Does the patient take opioid/narcotic medication? Who prescribed the medication? _____ How long has the patient been taking the medication? _____ Does the patient take any non-prescribed opioid/narcotic medication? ☐ Yes ☐ No	☐ Yes ☐ No
Does the patient have a history of substance abuse? Is the patient in a recovery program? How long has the patient been clean or sober? _____	☐ Yes ☐ No ☐ Yes ☐ No

Spiritual	
What is the patient's spiritual/religious beliefs? _____	
Is the patient affiliated with a religious organization?	☐ Yes ☐ No
Would the patient like someone to connect them with an organization in their community?	☐ Yes ☐ No

Financial	
Does the patient pay their own bills and manage their finances?	☐ Yes ☐ No
Does the patient have a designated power of attorney (POA)? Name: _____ Company: _____ Telephone: _____ Email: _____	☐ Yes ☐ No
Can the patient afford their medication?	☐ Yes ☐ No
Has the patient filled their new prescriptions?	☐ Yes ☐ No
If the patient has not obtained their prescriptions due to financial restraints, are they aware they can apply for assistance?	☐ Yes ☐ No
Does the patient understand the reason the medication was prescribed to them?	☐ Yes ☐ No
Can the patient afford proper nutrition (food)?	☐ Yes ☐ No
Does the patient have access to the food suitable to their dietary needs in the home?	☐ Yes ☐ No
Does the patient know what their dietary restrictions are?	☐ Yes ☐ No

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Notes

Social Work Care Plan

Name: _____ Signature: _____ Date: _____