COMMUNITY HEALTH WORKER - **INITIAL ASSESSMENT**

GENERAL ASSESSMENT

General

Assessment completed with

☐Patient ☐Spouse/Sig ☐Child/Children ☐Caregiver ☐Friend ☐Guardian ☐Other: _____

Patient would like caregiver to assist with plan of care ☐Yes ☐No ☐Needs Follow Up

Patient lives with

☐Alone ☐Family Members ☐Friends ☐Legal Guardian ☐Paid Care Giver ☐Spouse/Sig Other ☐ Homeless Shelter

☐Other: _____

ADL Assessment

Level of independence

☐Dependent with ADLs ☐Dependent with Functional transfers ☐Dependent with homemaking

☐Indep w/ ADLs & Func Transfers ☐Indep w/ homemaking & ambulation ☐Indep w/ homemaking, wheelchair

☐Indep w/ all ADLs ☐Needs assistance with ADLs ☐Needs assistance with homemaking

☐Needs assist w/ Func Transfers ☐Other: _____

Receives help from

☐Family ☐Friends ☐Home Health ☐Housekeeper ☐Neighbor ☐Caregiver ☐OP Therapy ☐NA

☐Other: _____

Assistive devices

☐None ☐AVAP ☐Cane ☐Chair Lift ☐Commode 3 in 1 ☐Contact Lenses ☐Crutches ☐Elevated Toilet

☐Glasses ☐Hearing Aid ☐Hospital bed ☐Hoyer lift ☐Medication Pump ☐Prosthesis ☐Ramp ☐Rollator

☐Scooter, Moto... ☐Shower Chair ☐Walker ☐Wheelchair, Manual ☐Wheelchair, Motor

Current method of transportation

☐Self ☐Family/Friends ☐Medical Transport ☐Shore Transit ☐Taxi ☐Bus ☐Walks ☐Other: _____

Medications

Who assists with medication management

☐NA ☐Self ☐ Family ☐ Pharmacy ☐Friend ☐ Neighbor ☐Caregiver ☐Home Health

Medication management assessment

☐Has all current meds ☐Taking meds as prescribed ☐Not taking meds as prescribed

Medication management aides

☐Pill Box ☐Delivery Service ☐Medication Calendar ☐Medication Reminders ☐Mobile App ☐Bubble Packs

Barriers to medication success

☐None ☐Complexity of Med Regimen ☐Financial Barriers ☐Side Effects ☐Too many medications

☐Other: _____

COMMUNITY HEALTH WORKER - **INITIAL ASSESSMENT**

Current Services

Community Services

☐None ☐Aide ☐Adult Day Care ☐Adult Protective Services ☐Child Protective Services ☐Community Health Worker

☐Counseling ☐Gifted Program ☐Law Enforcement ☐Mental Health Services ☐Occupational Therapy ☐Physical Therapy

☐Respite Care ☐Speech Therapy ☐Social Worker ☐Special Education ☐TANF ☐Other:

_____

Food/Nutrition Program Participation

☐Food Bank ☐Food panty ☐SNAP ☐Meals on Wheels ☐Moveable Feast ☐Tube Feeding ☐TPN ☐ WIC

☐Other: _____

Does patient have home health services? ☐Yes ☐No

Home Health Service Provider

☐None ☐Amedisys ☐Bayada ☐Beebe HH ☐Christiana Care ☐Coastal Home Care ☐Encompass

☐Home Call ☐Millennium Home ☐PHS Salisbury ☐PHC Ocean Pines ☐PHC ☐Other: _____

Has there been contact by the HH Agency? ☐Yes ☐No

Has Home Health visit been made? ☐Yes ☐ No

Current Home Treatments? Yes No

☐None ☐Apnea monitor ☐Blood Pressure ☐Blood glucose ☐CPAP/BIPAP ☐Dialysis ☐Dressing Changes ☐Insulin Pump

☐IV Therapy ☐Nebulizer ☐Oxygen ☐Respiratory Care ☐Scale ☐TPN ☐Trach ☐Other: _____

DME Provider

☐Apple ☐American Home Patient ☐Apria ☐Bayview ☐FirstChoice ☐Lincare ☐Peninsula Home Care

☐Other: _____

Hospice

☐Aveanna(DE) ☐Coastal Hospice (MD) ☐Compass (MD) ☐Compassionate Care ☐Delaware Hospice(DE)

☐Season's Hospice(DE) ☐Vitas(DE)

Other

Barriers to Care

☐None ☐Bug Infestation ☐Cognitive Impairment ☐External stairs ☐Internal stairs ☐ Health Literacy ☐Hearing Impairment

☐Language barrier ☐No Cooling ☐No Electric ☐No Heat ☐No Phone ☐No Running water ☐No Shower/tub first floor

☐Pets ☐Unable to use stairs ☐Upstairs bedroom ☐Visual impairment ☐Weapons

☐Other: _____

COMMUNITY HEALTH WORKER - **INITIAL ASSESSMENT**

PHQ-9

Over the past two weeks, how often have you been bothered by any of the following problems?

Will the patient answer the depression risk questions? ☐Yes ☐No

Little interest or pleasure in doing things

☐Not at all (0) ☐Several Days (1) ☐More than half the days (2) ☐Nearly every day (3)

Feeling down, depressed, or hopeless

☐Not at all (0) ☐Several Days (1) ☐More than half the days (2) ☐Nearly every day (3)

ASK THE FOLLOWING ONLY IF THE TOTALS FOR THE ABOVE EQUALS THREE (3) OR HIGHER:

Trouble falling asleep or staying asleep or sleeping too much?

☐Not at all (0) ☐Several Days (1) ☐More than half the days (2) ☐Nearly every day (3)

Feeling Tired or having little energy?

☐Not at all (0) ☐Several Days (1) ☐More than half the days (2) ☐Nearly every day (3)

Poor appetite or overeating?

☐Not at all (0) ☐Several Days (1) ☐More than half the days (2) ☐Nearly every day (3)

Feeling bad about yourself?

☐Not at all (0) ☐Several Days (1) ☐More than half the days (2) ☐Nearly every day (3)

Trouble concentrating on things, such as reading the newspaper or watching TV?

☐Not at all (0) ☐Several Days (1) ☐More than half the days (2) ☐Nearly every day (3)

Moving or speaking so slowly that other people could have noticed? Or the opposite, being so fidgety or restless that you have been moving around a lot more than usual?

☐Not at all (0) ☐Several Days (1) ☐More than half the days (2) ☐Nearly every day (3)

Thoughts that you would be better off dead or hurting yourself in some way?

☐Not at all (0) ☐Several Days (1) ☐More than half the days (2) ☐Nearly every day (3)

PAM ASSESSMENT

Assessment Type: ☐Initial ☐ Follow Up

Assessment Date: _____

Assessment Score: _____

PAM Score Level: ☐ 1 ☐ 2 ☐ 3 ☐ 4

COMMUNITY HEALTH WORKER - **INITIAL ASSESSMENT**

SOCIAL DETERMINANTS OF HEALTH - I

Physical Activity

On average, how many days per week o you engage in moderate to strenuous exercise (like a brisk walk)?

☐0 days ☐1 day ☐2 days ☐3 days ☐4 days ☐5 days ☐6 days ☐7 days ☐ Patient Refused

On average, how many minutes do you engage in exercise at this level?

☐0 min ☐10 min ☐20 min ☐30 min ☐40 min ☐50 min ☐60 min ☐70 min ☐80 min ☐90 min ☐100 min

☐110 min ☐120 min ☐130 min ☐140 min ☐150+ min ☐Patient refused

Financial Resources Strain

How hard is it for you to pay for the very basics like food, housing, medical care and heating?

☐Very Hard ☐ Hard ☐Somewhat hard ☐Not very hard ☐Not hard at all ☐Patient Refused

Monthly Income: _____ (ENTER IN COMMENTS)

(Children's HealthWatch) Housing Screener

In the last 12 months, was there a time when you were not able to pay the mortgage or rent on time?

☐ Yes ☐No ☐Patient Refused

In the last 12 months, how many places have you lived? ENTER NUMBER: _____

In the last 12 months, was there a time when you did not have a steady place to sleep or slept in a shelter (including now)?

☐ Yes ☐No ☐Patient Refused

Transportation Needs

In the past 12 months, has lack of transportation kept you from medical appointments or from getting medications?

☐ Yes ☐No ☐Patient Refused

In the past 12 months, has lack of transportation kept you from meetings, work, or from getting things needed for daily living?

☐ Yes ☐No ☐Patient Refused

Food Insecurity

Within the past 12 months, you worried that your food would run out before you got the money to buy more

☐Never true ☐Sometimes true ☐Often true ☐Patient Refused

Within the last 12 months, the food you bought just didn't last and you didn't have the money to get more

☐Never true ☐Sometimes true ☐Often true ☐Patient Refused

Stress

Do you feel stress – tense, restless, nervous, or anxious, or unable to sleep at night because your mind is troubled all the time these days?

☐Not at all ☐Only a little ☐ To some extent ☐Rather much ☐Very much ☐Patient Refused

COMMUNITY HEALTH WORKER - **INITIAL ASSESSMENT**

SOCIAL DETERMINANTS OF HEALTH II – *OPTIONAL*

Social Connections

In a typical week, how many times do you talk on the phone with family, friends, or neighbors?

☐Never ☐Once a week ☐Twice a week ☐Three times a week ☐More than three times a week ☐Patient refused

How often do you get together with friends or relatives

☐Never ☐Once a week ☐Twice a week ☐Three times a week ☐More than three times a week ☐Patient refused

How often do ou attend church or religious services?

☐Never ☐1-4 times per year ☐ More than 4 times per year ☐Patient refused

Do you belong to any clubs or organizations such as church groups, unions, fraternal or athletic groups or school groups?

☐Yes ☐No ☐Patient Reused

How often do you attend meetings of the clubs or organizations you belong to?

☐Never ☐1-4 times per year ☐ More than 4 times per year ☐Patient refused

Are you married, widowed, divorced, separated, never married or living with a partner?

☐Married ☐Widowed ☐Divorced ☐Separated ☐Never married ☐Living with partner ☐Patient Refused

Intimate Partner Violence

Within the last year, have you been afraid of your partner or ex-partner?

☐Yes ☐No ☐Patient Reused

Within the last year, have you been humiliated or emotionally abused in other ways by your partner or ex-partner?

☐Yes ☐No ☐Patient Reused

Within the lst year, ave you been kicked, hit, slapped, or otherwise physically hurt by your partner or ex-partner

☐Yes ☐No ☐Patient Reused

Withing the last year, have you been raped or forced to have any kind of sexual activity you your partner or ex-partner

☐Yes ☐No ☐Patient Reused

Alcohol Use

How often do you have a drink containing alcohol?

☐Never ☐Monthly or less ☐2-4 times a month ☐2-3 times a week ☐4 or more times a week ☐Patient Refused

How many drinks containing alcohol do you have on a typical day when you are drinking?

☐1-2 ☐3-4 ☐5-6 ☐7-9 ☐10 or more

COMMUNITY HEALTH WORKER - **INITIAL ASSESSMENT**

TOBACCO AND SUBSTANCE USE - SEXUAL ACTIVITY - *OPTIONAL*

Vaping

Vaping Status: ☐Current Every Day ☐Current Some Days ☐Former user ☐Never Assessed ☐Never Used

☐User – Current status unknown ☐Unknown if ever used

Number of Vaping Cartridges Per Day: _____

Vaping Start Date: _____

Vaping Quit Date: _____

Tobacco

Tobacco use: ☐Cigarettes ☐Pipe ☐Cigar
Start Date
Quit Date

Packs/Day: ☐0.25 ☐0.5 ☐1 ☐1.5 ☐2 ☐3

Years: ☐0.5 ☐1 ☐2 ☐3 ☐4 ☐5 ☐10 ☐15

Ready to Quit? ☐Yes ☐No

Counseling Given? ☐Yes ☐No

Smokeless Tobacco Use: ☐Snuff ☐Chew
Smokeless Tobacco Quit Date: _____

Substance Use

Drugs Used (including prescription drugs NOT prescribed to patient): ☐Yes ☐Not Currently ☐Never ☐Defer

Types: ☐Amphetamines ☐Amyl nitrate ☐ Anabolic steroids ☐Barbiturates ☐Benzodiazepines ☐ "Crack" cocaine ☐Cocaine ☐Codeine ☐Fentanyl ☐Flunitrazepam ☐GHB ☐Hashish ☐Heroin ☐Hydrocodone ☐Hydromorphone ☐Ketamine ☐LSD ☐Marijuana ☐MDMA(ecstasy) ☐Mescaline ☐Methamphetamine ☐Methaqualone ☐Methylphenidate ☐Morphine ☐Nitrous oxide ☐Opium ☐Oxycodone ☐PCP ☐Psilocybin ☐Solvent inhalants ☐Other: _____

Number of Uses/week:_____

Sexual Activity

Sexually Active: ☐Yes ☐Not Currently ☐Never ☐Defer

Birth Control/Protection: ☐Abstinence ☐Coitus interruptus ☐Condom Male ☐Condom Female ☐Diaphragm ☐Emergency Contraceptive ☐Implant ☐Injection ☐Inserts ☐IUD ☐OCP ☐Patch ☐Post-menopausal ☐Rhythm ☐Spermicide ☐Sponge ☐Surgical ☐Male Sterilization ☐Ring ☐Other ☐None

Partners: ☐Male ☐Female

EPIC Hospital Discharge ASSESSMENT TEMPLATE

HOSPITAL DISCHARGE ASSESSMENT – *For Recently Discharged Patients Only*

Discharged From:

☐ TH Peninsula ☐ TH Nanticoke ☐ AGH ☐ Beebe ☐ Christiana ☐ Johns Hopkins ☐ McCready

☐ Univ of MD

☐ Other: _____

Does the Patient have a PCP?

☐ Yes ☐ No

Does the patient have an appt with their PCP within 7 days of discharge?

☐ Yes ☐ No ☐ Greater than 7 days ☐ NA

Date of PCP Appt – Enter Date: _____

Names and dates of other post-discharge appointments:

_____

Interventions Taken:

☐ Verified appt date, time, provider ☐ Educated patient on importance of making appts

☐ Advised patient to make appts ☐ Urgent appt needed ☐ Assisted patient with PCP selection

☐ Provided number to obtain PCP ☐ Other:

Medications

Medication reviewed with patient/caregiver: ☐ Yes ☐ No ☐ Not Applicable

Is the patient having any side effect they believe may be caused by their medication? ☐ Yes ☐ No

Does the patient have all medications ordered at discharge? ☐ Yes ☐ No ☐ Not Applicable

What is keeping the patient from filling prescriptions?

☐ Pre-auth in progress ☐ Prior auth issues ☐ Financial ☐ Transportation ☐ Med Reconciliation Issues

EPIC Hospital Discharge ASSESSMENT TEMPLATE

HOSPITAL DISCHARGE ASSESSMENT – *For Recently Discharged Patients Only*

Discharge Disposition

Indicate any new services/referrals made on D/C from inpatient facility:

☐No new services required ☐Pharmacy ☐Respiratory Therapy ☐Cardiac Rehab ☐DME ☐Home Health

☐Telehealth Monitoring ☐Social Work Consult ☐Hospice ☐Long Term Care ☐Other: _____

Education

Did the patient receive a copy of the discharge instructions? ☐Yes ☐No

Has the patient made all appointment from DC instructions? ☐Yes ☐No

Interventions Taken:

☐Reviewed instructions with patient ☐Educated on My Chart ☐Referred to Health information Management

What is the patient's perception of their health status since discharge?

☐Improving ☐Same ☐Worsening ☐Retuned to baseline/stable ☐New symptoms unrelated to diagnosis

Is the patient/caregiver able to teach back signs and symptoms related to disease process for when to call PCP?

☐Yes ☐No

Is the patient/caregiver able to reach back signs and symptoms related to disease process for when to call 911?

☐Yes ☐No

COMMUNITY HEALTH WORKER - **COPD ASSESSMENT**

CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD) ASSESSMENT

Readmission

Was the patient readmitted within the last 30 days for COPD? ☐Yes ☐No

Symptom Assessment

Do you have shortness of breath today? ☐Yes ☐No

Are you limited in your activities at home due to shortness of breath? ☐Yes ☐No

Do you currently have a cough? ☐Yes ☐No

If yes, Is your cough productive? ☐Yes ☐No

Is a cough normal for you? ☐Yes ☐No

Do you currently have a fever or chills? ☐Yes ☐No

What things trigger your COPD? _____

Medication/Treatments

Does the patient have all respiratory meds at home? ☐Yes ☐No

Does the patient understand the proper techniques for each specific inhaler or device prescribed? ☐Yes ☐No

Barriers to Medication Success:

☐None ☐Complexity of Regimen ☐Financial Barriers ☐Side Effects ☐Too Many Meds

☐Other: _____

Does the patient wear oxygen? ☐Yes ☐No

Would the patient benefit from nicotine replacement? ☐Yes ☐No

☐Not needed ☐Yes, Refer to DE Quit ☐Yes, Refer to 1-800-Quit-Now

Has the patient had a PFT in the past year? ☐Yes ☐No

Does the patient see a pulmonologist? ☐Yes ☐No

Preventative Care

Have you had a flu vaccine this year? ☐Yes ☐No

Have you had a pneumonia vaccine? ☐Yes ☐No

Education Provided

☐COPD Stoplight tool ☐ COPD Booklet ☐ COPD Red Flags ☐Oxygen Use/Safety ☐Regular exercise

☐Importance of pneumonia vaccine ☐Proper use of inhaler/nebulizer ☐Medication Adherence

☐Triggers such as dust, smoking, etc ☐When to call the physician ☐Smoking cessation ☐Alcohol cessation

COMMUNITY HEALTH WORKER - **CONGESTIVE HEART FAILURE**

CONGESTIVE HEART FAILURE (CHF) ASSESSMENT

Symptom Assessment

Current Symptoms

☐None ☐Angina ☐Dyspnea on exertion ☐Fatigue ☐Leg edema ☐Orthostasis

☐Paroxysmal nocturnal dyspnea ☐Shortness of Breath ☐Weakness

Any swelling in the legs, feet, or ankles? ☐Yes ☐No

If yes, is the swelling normal for you? ☐Yes ☐No

Do you lose your breath while being active? ☐Yes ☐No

If yes, is losing your breath new? ☐Yes ☐No

Are you limited in your activities at home due to shortness of breath? ☐Yes ☐No

Are there activities you wish you could do more? _____

Dietary/ Fluid Assessment

Do you have a loss of appetite? ☐Yes ☐No

What type of foods do you eat? _____

Are you aware of foods that may be high in salt? ☐Yes ☐No

Are you aware of foods that contain potassium? ☐Yes ☐No

Do you have a functioning scale at home? ☐Yes ☐No

If yes, are you able to weigh yourself? ☐Yes ☐No

How often do you check your weight? ☐ Never ☐Daily ☐Weekly ☐Other

Provider Information

Do you see a cardiologist?

If yes, have you seen the cardiologist in the past 6 months? ☐Yes ☐No

Medication

Were any new cardiac meds prescribed at discharge? ☐Yes ☐No

Does the patient understand the meds and how they help? ☐Yes ☐No

Preventative Care

Have you had a flu vaccine this year? ☐Yes ☐No

Have you had a pneumonia vaccine? ☐Yes ☐No

Education Provided

☐CHF Stoplight tool ☐ CHF Booklet ☐ Daily weights ☐Monitoring weight gain ☐Regular exercise

☐Importance of pneumonia vaccine ☐Sodium and fluid restrictions ☐Reduce the use of sauces, soups

☐Use of fluid tracking apps/logs ☐When to call the physician ☐Smoking cessation ☐Alcohol cessation

COMMUNITY HEALTH WORKER - **DIABETES**

COMMUNITY HEALTH WORKER - **DIABETES**

DIABETES ASSESSMENT

Diabetic Assessment

What symptoms does the patient have with hyperglycemia?

☐ Denies Symptoms ☐Increased hunger/thirst ☐Increased urination ☐Blurry vision/vision changes

☐Chest pain ☐Fatigue/weakness ☐Foot paresthesia ☐Foot ulcerations ☐Weight Loss

What factors are contributing to high blood sugar?

☐Illness ☐Infection ☐Emotional Stress ☐Not taking medications ☐Eating more than usual/bad choices

☐Being less active than usual ☐Other: _____

What symptoms does patient have with hypoglycemia?

☐Denies symptoms ☐Shakes/tremors ☐Confusion ☐ Dizziness/lightheadedness ☐Cold sweats

☐Headaches ☐Hunger ☐Mood changes ☐Nervousness/anxiety ☐Pallor ☐Seizures

☐Sleepiness ☐Difficulty speaking

What factors are contributing to low blood sugar?

☐Skipping meals ☐Eating less than normal ☐Taking too much medication ☐More active than usual

☐Other: _____

Does the patient check their blood sugars? ☐Yes ☐No-Does not have machine/broken

If Yes, how often does patient check their blood sugars? ☐1-2/day ☐3-4/day ☐1-2/week ☐3-4/week ☐Other

If No: ☐Offered assistance in obtaining glucometer ☐Patient accepted assistance ☐Patient refused assistance

☐Notify CCM RN ☐Notify PCP ☐Other: _____

Blood Glucose Trend:

☐No change ☐Decreasing ☐Increasing ☐Fluctuating

Does the patient see an endocrinologist? ☐Yes ☐No

Education

Has patient attended Diabetic Education classes? ☐Yes ☐No

Has patient attended MNT classes? ☐Yes ☐No

Education Provided:

☐Diabetes Stoplight tool ☐ Diabetes Survival Skills Booklet ☐ Checking Blood Sugar

☐Metformin-monitoring creatinine levels Metformin-holding for 48 hours post dys/checking BUN/creatinine

☐Regular exercise ☐Importance of pneumonia/Flu vaccine ☐Avoiding/limiting sugar/simple carbs

☐No skipping meals/small frequent meals ☐S/S high blood sugar ☐S/S low blood sugar

☐Use of Medical ID bracelet ☐Keeping a blood sugar log ☐Proper storage and admin of insulin

☐Diabetic foot care ☐Annual diabetic eye exam ☐When to call the physician

INITIAL ASSESSMENT NOTE:

Patient Name: _____

Date and Time Visit/Contact: ____/____/_____ _____:_____ ☐ AM ☐ PM

Overall Goals of Care:

☐ Take Medications daily as prescribed

☐ Attend appointments as arranged

☐ Participate in mild-moderate exercise 3-5 times per week

☐ Stop smoking

☐ Decrease smoking

☐ Possess good understanding of existing chronic disease conditions

☐ Other: _____

_____

Patient Personal Goal(s): _____

_____

_____

Patient Confidence in Achieving Goal(s):

☐ 1-Not Confident ☐ 2- Somewhat Confident ☐ 3-Mostly Confident ☐ 4-Confident

☐ 5-Very Confident

Appointments: ☐ Reviewed and confirmed

☐ Confirmed patient has transportation to and from appointments

☐ Patient does not have transportation to and from appointments

☐ Patient has history of frequently missing appointments

☐ Patient currently plans to attend all appointments as arranged

☐ Encouraged attendance and emphasized its impact on patient's overall health and plan of care

☐ Patient has attended all appointments as scheduled

☐ Other: _____

Referrals:

	A Place for Mom		ACT – Assertive Community Tx		APS – Adult Protective Services
	Advance Care Planning		Adult Day Care		Adult Evaluation and Review Services
	Alzheimer's Association		Behavioral health		Better Breathers Club – TPR
	Cardiac Rehab		Cardiologist		CCS-Care Coordination Specialist
	CHC – Dental		CHC – Transportation		CHW- Community Health Worker
	Coastal Home Care		Community/Church Food bank		Community For Life
	Compass/Choices		DART		Department of Social Services – DSS
	Diabetes Education – TPR		Diabetes Education – Apple Drug		Emergency Funding- Joseph House
	Emergency Fund–SBY Urban Min		Emergency Funding – Salvation Army		Emergency Funding-ShoreUp
	Emergency Room		Endocrinologist		Food
	Go-Getters, Inc		Homeless Shelter		Home Health
	HOPE		Hospice		Housing
	Insurance		Life Lilne		Local Health Department
	Lyft		MAC-Chronic Disease Management		MAC-Diabetes Education
	MAC – Falls		MAC-Financial Assistance		MAC-Gym
	MAC- Medication Assistance		MAC – PEARLS		MAC-Stepping On
	MAC – Tai Chi		MAP – Maryland Access Point		Maryland Food Bank
	Medical Nutrition Therapy		Medical Transportation		Medical Financial Assistance
	Mended Hearts		National Kidney Foundation		Nat. Kidney Foundation-EMERGENCY
	Nephrologist		Palliative Care		PCP
	Peninsula Heart Line		Pharmacy		Pill Packaging
	TPR Financial Assistance		Pulmonary Rehab		Remote Patient Monitoring (RPM)
	Renal Support Group – TPR		Shore Transit		Shore Transit – Curb to Curb
	Silver Stay		Social Work		TLC Dental

☐Confirmed that patient is engaged and plans to participate

☐OTHER: _____

_____

Updated care sheet as indicated. Encouraged patient to place on refrigerator or in area of high visibility.

CHW and CCS contact information provided for non-emergent needs. Encouraged him/her to call should any concerns arise. For any health-related questions or concerns that occur after hours or on weekends, encouraged patient to call their provider. If unavailable, encouraged him/her to utilize Team Health 24-hour help line at 410-543-7762.

FOLLOW UP/SUBSEQUENT NOTE:

Patient Name: _____

Date and Time Visit/Contact: ____/____/_____ _____:_____ ☐ AM ☐ PM

Patient Personal Goal(s): _____

Patient Confidence in Achieving Goal(s):

☐ 1-Not Confident ☐ 2- Somewhat Confident ☐ 3-Mostly Confident ☐ 4-Confident

☐ 5-Very Confident

Appointments: ☐ Reviewed and confirmed

☐ Confirmed patient has transportation to and from appointments

☐ Patient does not have transportation to and from appointments

☐ Patient has history of of frequently missing appointments

☐ Patient currently plans to attend all appointments as arranged

☐ Encouraged attendance and emphasized its impact on patient's overall health and plan of care

☐ Patient has attended all appointments as scheduled

☐ Other: _____

Referrals:

☐	A Place for Mom	☐	ACT – Assertive Community Tx	☐	APS – Adult Protective Services
☐	Advance Care Planning	☐	Adult Day Care	☐	Adult Evaluation and Review Services
☐	Alzheimer's Association	☐	Behavioral health	☐	Better Breathers Club – TPR
☐	Cardiac Rehab	☐	Cardiologist	☐	CCS-Care Coordination Specialist
☐	CHC – Dental	☐	CHC – Transportation	☐	CHW- Community Health Worker
☐	Coastal Home Care	☐	Community/Church Food bank	☐	Community For Life
☐	Compass/Choices	☐	DART	☐	Department of Social Services – DSS
☐	Diabetes Education – TPR	☐	Diabetes Education – Apple Drug	☐	Emergency Funding- Joseph House
☐	Emergency Fund–SBY Urban Min	☐	Emergency Funds – Salvation Army	☐	Emergency Funding-ShoreUp
☐	Emergency Room	☐	Endocrinologist	☐	Food
☐	Go-Getters, Inc	☐	Homeless Shelter	☐	Home Health
☐	HOPE	☐	Hospice	☐	Housing
☐	Insurance	☐	Life Lilne	☐	Local Health Department
☐	Lyft	☐	MAC-Chronic Disease Management	☐	MAC-Diabetes Education
☐	MAC – Falls	☐	MAC-Financial Assistance	☐	MAC-Gym
☐	MAC- Medication Assistance	☐	MAC – PEARLS	☐	MAC-Stepping On
☐	MAC – Tai Chi	☐	MAP – Maryland Access Point	☐	Maryland Food Bank
☐	Medical Nutrition Therapy	☐	Medical Transportation	☐	Medical Financial Assistance
☐	Mended Hearts	☐	National Kidney Foundation	☐	Nat. Kidney Foundation-EMERGENCY
☐	Nephrologist	☐	Palliative Care	☐	PCP
☐	Peninsula Heart Line	☐	Pharmacy	☐	Pill Packaging
☐	TPR Financial Assistance	☐	Pulmonary Rehab	☐	Remote Patient Monitoring (RPM)
☐	Renal Support Group – TPR	☐	Shore Transit	☐	Shore Transit – Curb to Curb
☐	Silver Stay	☐	Social Work		

ASSESSMENT UPDATE NOTES:

Instructed patient this will be last CHW visit. Informed that CCS will be completing follow up phone call in one to two weeks to ensure that goals are met and there have been no changes in patient condition.

CHW and CCS contact information provided for non-emergent needs. Encouraged him/her *to call should any concerns arise. For any health-related questions or concerns that occur after hours or on weekends, encouraged patient to call their provider. If unavailable, encouraged* him/her *to utilize Team Health 24-hour help line at 410-543-7762.*

Thanked patient for participating in the Community Health Worker Program.

FINAL/DISCHARGE NOTE:

Patient Name: _____

Date and Time Visit/Contact: ____/____/_____ _____:_____ ☐ AM ☐ PM

Overall Goals of Care: ☐ Goals Met ☐ Goals Not Met

Comments: _____

_____

_____

Patient Personal Goal(s): _____

_____

_____

Need for ongoing CHW support: ☐ Yes ☐ No

Comments: _____

_____

_____

Red Flag Review Sheet reviewed with patient. Patient denies any concerning signs or symptoms at this time. Reinforced need to call MD or 911 should anything occur. Patient verbalized understanding.

Appointments: ☐ Reviewed and confirmed

☐ Confirmed patient has transportation to and from appointments

☐ Patient does not have transportation to and from appointments

☐ Patient has history of of frequently missing appointments

☐ Patient currently plans to attend all appointments as arranged

☐ Encouraged attendance and emphasized its impact on patient's overall health and plan of care

☐ Patient has attended all appointments as scheduled

☐ Other: _____

☐Confirmed that patient is engaged and plans to participate

☐OTHER: _____

ASSESSMENT UPDATE NOTES:

_____

_____

_____

_____

_____

_____

_____

_____

Updated care sheet as indicated. Encouraged patient to place on refrigerator or in area of high visibility.

CHW and CCS contact information provided for non-emergent needs. Encouraged him/her to call should any concerns arise. For any health-related questions or concerns that occur after hours or on weekends, encouraged patient to call their provider. If unavailable, encouraged him/her to utilize Team Health 24-hour help line at 410-543-7762.