# Wooster Community Hospital Community Care Network
# Screening Identification Tool

Patient's Name:_____ Sex _____ Date_____

Age: _____ DOB_____ Date of Admission_____

Primary Physician_____

| Inclusion Criteria* | Yes | No | Number | Comments |
|---|---|---|---|---|
| Admitted to hospital in past 6 months? | | | | |
| Emergency room visits in past 6 months? | | | | |
| Uses 5 or more medications? | | | | |
| Chronic disease | | | | |
| Delayed seeking care that worsened symptoms? | | | | |
| List chronic diseases: | | | | |

***If patient meets inclusion criteria, complete the remainder of this form and the supplemental Health Profile.**

| Exclusion Criteria | Yes | No | Comments |
|---|---|---|---|
| Enrolled /active participant in Hospice | | | |
| Severe dementia-unable to participate in care | | | |
| Mental health issues only | | | |
| No chronic or co-morbid conditions | | | |
| Primary Care Provider Date Last Seen: _____ Appointment Scheduled? * | | | |

***If no appointment /patient has not seen PCP in 1+ year/ or has no PCP then schedule or get a PCP.**

| Background Information | Yes | No | Comments |
|---|---|---|---|
| Convicted of a crime | | | |

| Social-Economic | Yes | No | Comments |
|---|---|---|---|
| Financially solvent | | | |
| No discretionary resources and/ or underinsured | | | |
| Low income | | | |
| No income | | | |
| Public assistance dependent | | | |
| Not using public assistance | | | |
| Adequate resources to cover medication costs | | | |

| **Housing Situation** (choose one) | | **Comments** |
|---|---|---|
| | No housing concerns | |
| | Boarding home | |
| | Shelter/ unsafe housing | |
| | Street/ no housing | |

| **Education Level** (choose one) | | **Comments** |
|---|---|---|
| | > High school | |
| | High school | |
| | Some high school or GED | |
| | < 8th Grade | |
| | Cognitively impaired | |

| **Self-Health Rating** | **Good** | **Fair** | **Poor** | **Unable to respond** | **Comments** |
|---|---|---|---|---|---|
| Patient rates health as: | | | | | |

| **Adherence Potential** (choose one) | | **Comments** |
|---|---|---|
| | Fully cooperative | |
| | Limited cooperation | |
| | Unable to cooperate/uncooperative | |

| **Health Conditions / Comorbidities** | **# Conditions Identified** **(see page 3)** | **Comments** |
|---|---|---|
| | | |

| **Psychosocial Stressors- impacting medical outcomes** | **# Issues Identified** **(see page 3)** | **Comments** |
|---|---|---|
| | | |

| **Social Support** | **# Issues Identified** **(see page 4)** | **Comments** |
|---|---|---|
| | | |

| **Medication Compliance** | **Yes** | **No** | **Comments** |
|---|---|---|---|
| Understands how to take medications | | | |
| Understands purpose of medications | | | |
| Remembers to take medications | | | |
| Medication education needed | | | |

| Mental Health | Yes | No | Comment |
|---|---|---|---|
| Diagnosis of behavioral issue | | | |
| History of behavioral issue and/or treatment | | | |
| Current behavioral issue | | | |
| Under current treatment* | | | |
| Medication management for behavioral issue | | | |
| ***If yes to current treatment, who are they seeing:_____** | | | |

| Fall Risk | Yes | No | Comment |
|---|---|---|---|
| History of falls | | | |
| Fall last month no treatment* | | | |
| ED/Hospitalized for fall in last 6 months* | | | |
| Multiple falls with injury in last year* | | | |
| ***Perform a home safety evaluation** | | | |

| **Health Conditions / Comorbidities** (check all that apply) | | | | | |
|---|---|---|---|---|---|
| | Congestive heart failure (CHF) | | Diabetes , uncomplicated | | Coagulopathy |
| | Cardiac arrhythmias | | Diabetes-complicated | | Obesity |
| | Valvular disease | | Hypothyroidism | | Weight loss |
| | Pulmonary circulation disorder | | Kidney disease | | Fluid and electrolyte disorder |
| | Peripheral vascular disorder | | Renal failure | | Blood loss anemia |
| | Hypertension controlled | | Liver disease | | Deficiency anemias |
| | Hypertension uncontrolled | | Peptic ulcer disease (excluding bleeding) | | Alcohol abuse |
| | Paralysis | | AIDS | | Drug abuse |
| | Stroke | | Lymphoma | | Psychoses |
| | Seizure | | Metastatic cancer | | Depression |
| | Other neurological disorders | | Solid tumor without metastasis | | Anxiety disorder |
| | Chronic pulmonary disease | | Rheumatoid arthritis/collagen vascular disease | | Dementia |
| | | | | | Chronic Pain |

| **Psychosocial Stressors** (check all that apply) | | | | | |
|---|---|---|---|---|---|
| | Change in personal habits | | Insurance | | Personal Injury/illness |
| | Child Care | | Legal Issues | | Relating to God |
| | Children | | Loss of faith | | Transportation |
| | Current treatment for mental health | | Loss: _____ | | Work/School |
| | Death of a loved one or friend | | Parent | | Other: _____ |
| | Finances | | Partner | | |

| **Social Support Needs** (check all that apply) | | | | | |
|---|---|---|---|---|---|
| | Difficulty with accessing services | | Housing | | Medication financial assistance |
| | Equipment needed | | In home assistance | | Need home or community services |
| | Financial | | Lack of social support | | Passport |
| | Food | | Legal | | Safety |
| | Food kitchen | | Meals on Wheels | | Transportation |
| | Food stamps | | Medical Alert | | Other: _____ |
| | Home Maker/Aide | | Medical insurance | | |

**Completed By:_____ Date:_____**


References:

Camden coalition of healthcare providers. (2014). Care management forms. Retrieved April / 10, 2014, Retrieved from http://www.camdenhealth.org/cross-site-learning/resources/care-intervetions/care-management-information/

Elixhauser, A., Steiner, C., Harris, D. R., & Coffey, R. M. (1998). Comorbidity measures for use with administrative data. *Medical Care, 36*(1), 8-27.