CARE MANAGEMENT EVALUATION

CLIENT____DATE ___________/___/___________________________ _

ADDRESS____ZIP____________________

TELEPHONE NUMBER(_________)____

DATE OF BIRTH_____________________ AGE__________ SEX___________________________

MARITAL STATUS___________________ RACIAL/ETHNIC BACKGROUND_____________________

SOCIAL SECURITY NUMBER________________MEDICARE NUMBER_______________________________

INSURANCE INFORMATION 1._____________POLICY NUMBER___________________________________

POLICY NUMBER____

EMPLOYMENT HISOTRY (employed/retired/disability)____

PRIMARY M.D.____TELEPHONE_________________________

ADDRESS____

OTHER M.D.'s____TELEPHONE_________________________

ADDRESS____

OTHER M.D.'s____TELEPHONE_________________________

ADDRESS____

DATE OF LAST PHYSICAL___________________**DATE OF LAST HOSPITALIZATION**_______________

PRIMARY HEALTH PROBLEMS

1.____

2.____

3.____

PAST HEALTH/HOSPITAL HISTORY

1.____

2.____

3.____

PAST HEALTH/HOSPITAL HISTORY

1.____________________________________ 4.______________________________

2.____________________________________ 5.______________________________

3.____________________________________ 6.______________________________

PHARMACY__________________________________**TELEPHONE**_____________________________

ADDRESS__________________________________

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STAFF INITIALS____________

CLIENT____ **DATE**________/________/________

PHYS.ASSESS./FUNC.	OPTIONAL NARRATIVE
☐**APPEARANCE** ☐**HEARING** ☐**VISION**	

☐SPEECH ☐IMPAIRED MOBILITY ☐INCONTINENT ☐NUTRITIONAL STATUS ☐OTHER	
ADJUSTMENT TO	
☐ACCEPTANCE ☐INADEQUATE UNDERSTANDING OF ILLNESS/PROBLEM ☐UNDERSTANDING OF TREATMENT ☐INADEQUATE COPING ☐DENIAL ☐AMBIVALENCE ☐GRIEF ☐OTHER	
MENTAL ASSESSMENT	
☐ALERT/ORIENTED X4 ☐JUDGEMENT ☐CONFUSION/MEMORY ☐SUBSTANCE______________ ☐PSYCH Dx________________	

STAFF________________

CLIENT____ DATE_________/ ________/________

PHYS.ASSESS./FUNC.	OPTIONAL NARRATIVE
☐MARRIED ☐WIDOWED ☐DIVORCED ☐SINGLE ☐SIGNIFICANT OTHER	
CHILDREN/FAMILY	**NAME:**
☐NONE	**ADDRESS:**
☐SUPPORTING FAMILY	**PHONE#:**

☐SUPPORTING FAMILY ☐SUPPORTING FAMILY FRIENDS/COMMUNITY ☐NEIGHBORS ☐FRIENDS ☐CHURCH(phone___________) ☐COMMUNITY AGENCY	NAME: ADDRESS: PHONE#: NAME ADDRESS: PHONE#:
HOME ENVIRONMENT	
☐ADEQUATE ☐ARCHITECTURAL ☐SAFETY ☐HOUSEKEEPING/YARD	
LEGAL INFOMRATION	
☐WILL/LIVING WILL ☐POA/HEALTH CARE POA ☐TRUSTEE/GUARDIAN ☐NAME OF ATTORNEY	

STAFF_______________

CLIENT____ DATE________/________/_______

FINANCIAL INFOMRATION	OPTIONAL NARRATIVE
☐INCOME ADEQUATE ☐INCOME INADEQUATE ☐INSURANCE ADEQUATE ☐INSURANCE INADEQUATE ☐UNCOVERED SERVICES/NEEDS	
ENTITLEMENTS/BENEFITS	
☐TITLE XX ☐MEDICAID ☐MEDICARE ☐SOCIAL SECURITY ☐MEALS ON WHEELS	

☐TRANSPORTATION ☐VA BENEIFTS ☐OTHER	

CLINICAL

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INITIAL INTERVENTION

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PLANNED INTERVENTION

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STAFF_______________